



General Assembly

Amendment

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LCO No. 6427

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Offered by:

SEN. CRISCO, 17th Dist.

REP. MEGNA, 97th Dist.

To: Subst. Senate Bill No. **1158**

File No. 326

Cal. No. 227

***"AN ACT CONCERNING UTILIZATION REVIEW, GRIEVANCES
AND EXTERNAL APPEALS PROCESSES OF HEALTH
CARRIERS."***

1 Strike everything after the enacting clause and substitute the
2 following in lieu thereof:

3 "Section 1. (NEW) (*Effective July 1, 2011*) As used in this section and
4 sections 2 to 13, inclusive, of this act:

5 (1) "Adverse determination" means:

6 (A) The denial, reduction, termination or failure to provide or make
7 payment, in whole or in part, for a benefit under the health carrier's
8 health benefit plan requested by a covered person or a covered
9 person's treating health care professional, based on a determination by
10 a health carrier or its designee utilization review company:

11 (i) That, based upon the information provided, (I) upon application
12 of any utilization review technique, such benefit does not meet the

13 health carrier's requirements for medical necessity, appropriateness,
14 health care setting, level of care or effectiveness, or (II) is determined to
15 be experimental or investigational;

16 (ii) Of a covered person's eligibility to participate in the health
17 carrier's health benefit plan; or

18 (B) Any prospective review, concurrent review or retrospective
19 review determination that denies, reduces or terminates or fails to
20 provide or make payment, in whole or in part, for a benefit under the
21 health carrier's health benefit plan requested by a covered person or a
22 covered person's treating health care professional.

23 "Adverse determination" includes a rescission of coverage
24 determination for grievance purposes.

25 (2) "Authorized representative" means:

26 (A) A person to whom a covered person has given express written
27 consent to represent the covered person for the purposes of this section
28 and sections 2 to 13, inclusive, of this act;

29 (B) A person authorized by law to provide substituted consent for a
30 covered person;

31 (C) A family member of the covered person or the covered person's
32 treating health care professional when the covered person is unable to
33 provide consent;

34 (D) A health care professional when the covered person's health
35 benefit plan requires that a request for a benefit under the plan be
36 initiated by the health care professional; or

37 (E) In the case of an urgent care request, a health care professional
38 with knowledge of the covered person's medical condition.

39 (3) "Best evidence" means evidence based on (A) randomized
40 clinical trials, (B) if randomized clinical trials are not available, cohort

41 studies or case-control studies, (C) if such trials and studies are not
42 available, case-series, or (D) if such trials, studies and case-series are
43 not available, expert opinion.

44 (4) "Case-control study" means a retrospective evaluation of two
45 groups of patients with different outcomes to determine which specific
46 interventions the patients received.

47 (5) "Case-series" means an evaluation of a series of patients with a
48 particular outcome, without the use of a control group.

49 (6) "Certification" means a determination by a health carrier or its
50 designee utilization review company that a request for a benefit under
51 the health carrier's health benefit plan has been reviewed and, based
52 on the information provided, satisfies the health carrier's requirements
53 for medical necessity, appropriateness, health care setting, level of care
54 and effectiveness.

55 (7) "Clinical peer" means a physician or other health care
56 professional who holds a nonrestricted license in a state of the United
57 States and in the same or similar specialty as typically manages the
58 medical condition, procedure or treatment under review.

59 (8) "Clinical review criteria" means the written screening
60 procedures, decision abstracts, clinical protocols and practice
61 guidelines used by the health carrier to determine the medical
62 necessity and appropriateness of health care services.

63 (9) "Cohort study" means a prospective evaluation of two groups of
64 patients with only one group of patients receiving a specific
65 intervention or specific interventions.

66 (10) "Commissioner" means the Insurance Commissioner.

67 (11) "Concurrent review" means utilization review conducted
68 during a patient's stay or course of treatment in a facility, the office of a
69 health care professional or other inpatient or outpatient health care
70 setting, including home care.

71 (12) "Covered benefits" or "benefits" means health care services to
72 which a covered person is entitled under the terms of a health benefit
73 plan.

74 (13) "Covered person" means a policyholder, subscriber, enrollee or
75 other individual participating in a health benefit plan.

76 (14) "Emergency medical condition" means a medical condition
77 manifesting itself by acute symptoms of sufficient severity, including
78 severe pain, such that a prudent lay-person with an average
79 knowledge of health and medicine, acting reasonably, would have
80 believed that the absence of immediate medical attention would result
81 in serious impairment to bodily functions or serious dysfunction of a
82 bodily organ or part, or would place the person's health or, with
83 respect to a pregnant woman, the health of the woman or her unborn
84 child, in serious jeopardy.

85 (15) "Emergency services" means, with respect to an emergency
86 medical condition:

87 (A) A medical screening examination that is within the capability of
88 the emergency department of a hospital, including ancillary services
89 routinely available to the emergency department to evaluate such
90 emergency medical condition; and

91 (B) Such further medical examination and treatment, to the extent
92 they are within the capability of the staff and facilities available at a
93 hospital, to stabilize a patient.

94 (16) "Evidence-based standard" means the conscientious, explicit
95 and judicious use of the current best evidence based on an overall
96 systematic review of medical research when making determinations
97 about the care of individual patients.

98 (17) "Expert opinion" means a belief or an interpretation by
99 specialists with experience in a specific area about the scientific
100 evidence pertaining to a particular service, intervention or therapy.

101 (18) "Facility" means an institution providing health care services or
102 a health care setting. "Facility" includes a hospital and other licensed
103 inpatient center, ambulatory surgical or treatment center, skilled
104 nursing center, residential treatment center, diagnostic, laboratory and
105 imaging center, and rehabilitation and other therapeutic health care
106 setting.

107 (19) "Final adverse determination" means an adverse determination
108 (A) that has been upheld by the health carrier at the completion of its
109 internal grievance process, or (B) for which the internal grievance
110 process has been deemed exhausted.

111 (20) "Grievance" means a written complaint or, if the complaint
112 involves an urgent care request, an oral complaint, submitted by or on
113 behalf of a covered person regarding:

114 (A) The availability, delivery or quality of health care services,
115 including a complaint regarding an adverse determination made
116 pursuant to utilization review;

117 (B) Claims payment, handling or reimbursement for health care
118 services; or

119 (C) Any matter pertaining to the contractual relationship between a
120 covered person and a health carrier.

121 (21) (A) "Health benefit plan" means an insurance policy or contract,
122 certificate or agreement offered, delivered, issued for delivery,
123 renewed, amended or continued in this state to provide, deliver,
124 arrange for, pay for or reimburse any of the costs of health care
125 services;

126 (B) "Health benefit plan" does not include:

127 (i) Coverage of the type specified in subdivisions (5) to (9), inclusive,
128 (14) and (15) of section 38a-469 of the general statutes or any
129 combination thereof;

- 130 (ii) Coverage issued as a supplement to liability insurance;
- 131 (iii) Liability insurance, including general liability insurance and
132 automobile liability insurance;
- 133 (iv) Workers' compensation insurance;
- 134 (v) Automobile medical payment insurance;
- 135 (vi) Credit insurance;
- 136 (vii) Coverage for on-site medical clinics;
- 137 (viii) Other insurance coverage similar to the coverages specified in
138 subparagraphs (B)(ii) to (B)(vii), inclusive, of this subdivision that are
139 specified in regulations issued pursuant to the Health Insurance
140 Portability and Accountability Act of 1996, P.L. 104-191, as amended
141 from time to time, under which benefits for health care services are
142 secondary or incidental to other insurance benefits;
- 143 (ix) (I) Limited scope dental or vision benefits, (II) benefits for long-
144 term care, nursing home care, home health care, community-based
145 care or any combination thereof, or (III) other similar, limited benefits
146 specified in regulations issued pursuant to the Health Insurance
147 Portability and Accountability Act of 1996, P.L. 104-191, as amended
148 from time to time, provided any benefits specified in subparagraphs
149 (B)(ix)(I) to (B)(ix)(III), inclusive, of this subdivision are provided
150 under a separate insurance policy, certificate or contract and are not
151 otherwise an integral part of a health benefit plan; or
- 152 (x) Coverage of the type specified in subdivisions (3) and (13) of
153 section 38a-469 of the general statutes or other fixed indemnity
154 insurance if (I) they are provided under a separate insurance policy,
155 certificate or contract, (II) there is no coordination between the
156 provision of the benefits and any exclusion of benefits under any
157 group health plan maintained by the same plan sponsor, and (III) the
158 benefits are paid with respect to an event without regard to whether
159 benefits were also provided under any group health plan maintained

160 by the same plan sponsor.

161 (22) "Health care center" has the same meaning as provided in
162 section 38a-175 of the general statutes.

163 (23) "Health care professional" means a physician or other health
164 care practitioner licensed, accredited or certified to perform specified
165 health care services consistent with state law.

166 (24) "Health care services" has the same meaning as provided in
167 section 38a-478 of the general statutes, as amended by this act.

168 (25) "Health carrier" means an entity subject to the insurance laws
169 and regulations of this state or subject to the jurisdiction of the
170 commissioner, that contracts or offers to contract to provide, deliver,
171 arrange for, pay for or reimburse any of the costs of health care
172 services, including a sickness and accident insurance company, a
173 health care center, a managed care organization, a hospital service
174 corporation, a medical service corporation or any other entity
175 providing a plan of health insurance, health benefits or health care
176 services.

177 (26) "Health information" means information or data, whether oral
178 or recorded in any form or medium, and personal facts or information
179 about events or relationships that relate to (A) the past, present or
180 future physical, mental, or behavioral health or condition of a covered
181 person or a member of the covered person's family, (B) the provision of
182 health care services to a covered person, or (C) payment for the
183 provision of health care services to a covered person.

184 (27) "Independent review organization" means an entity that
185 conducts independent external reviews of adverse determinations and
186 final adverse determinations. Such review entities include, but are not
187 limited to, medical peer review organizations, independent utilization
188 review companies, provided such organizations or companies are not
189 related to or associated with any health carrier, and nationally
190 recognized health experts or institutions approved by the Insurance

191 Commissioner.

192 (28) "Medical or scientific evidence" means evidence found in the
193 following sources:

194 (A) Peer-reviewed scientific studies published in or accepted for
195 publication by medical journals that meet nationally recognized
196 requirements for scientific manuscripts and that submit most of their
197 published articles for review by experts who are not part of the
198 editorial staff;

199 (B) Peer-reviewed medical literature, including literature relating to
200 therapies reviewed and approved by a qualified institutional review
201 board, biomedical compendia and other medical literature that meet
202 the criteria of the National Institutes of Health's Library of Medicine
203 for indexing in Index Medicus (Medline) or Elsevier Science for
204 indexing in Excerpta Medicus (EMBASE);

205 (C) Medical journals recognized by the Secretary of the United
206 States Department of Health and Human Services under Section
207 1861(t)(2) of the Social Security Act;

208 (D) The following standard reference compendia: (i) The American
209 Hospital Formulary Service - Drug Information; (ii) Drug Facts and
210 Comparisons; (iii) The American Dental Association's Accepted Dental
211 Therapeutics; and (iv) The United States Pharmacopoeia - Drug
212 Information;

213 (E) Findings, studies or research conducted by or under the auspices
214 of federal government agencies and nationally recognized federal
215 research institutes, including: (i) The Agency for Healthcare Research
216 and Quality; (ii) the National Institutes of Health; (iii) the National
217 Cancer Institute; (iv) the National Academy of Sciences; (v) the Centers
218 for Medicare and Medicaid Services; (vi) the Food and Drug
219 Administration; and (vii) any national board recognized by the
220 National Institutes of Health for the purpose of evaluating the medical
221 value of health care services; or

222 (F) Any other findings, studies or research conducted by or under
223 the auspices of a source comparable to those listed in subparagraphs
224 (E)(i) to (E)(v), inclusive, of this subdivision.

225 (29) "Medical necessity" has the same meaning as provided in
226 sections 38a-482a and 38a-513c of the general statutes.

227 (30) "Participating provider" means a health care professional who,
228 under a contract with the health carrier, its contractor or subcontractor,
229 has agreed to provide health care services to covered persons, with an
230 expectation of receiving payment or reimbursement directly or
231 indirectly from the health carrier, other than coinsurance, copayments
232 or deductibles.

233 (31) "Person" has the same meaning as provided in section 38a-1 of
234 the general statutes.

235 (32) "Prospective review" means utilization review conducted prior
236 to an admission or the provision of a health care service or a course of
237 treatment, in accordance with a health carrier's requirement that such
238 service or treatment be approved, in whole or in part, prior to such
239 service's or treatment's provision.

240 (33) "Protected health information" means health information (A)
241 that identifies an individual who is the subject of the information, or
242 (B) for which there is a reasonable basis to believe that such
243 information could be used to identify such individual.

244 (34) "Randomized clinical trial" means a controlled, prospective
245 study of patients that have been randomized into an experimental
246 group and a control group at the beginning of the study, with only the
247 experimental group of patients receiving a specific intervention, and
248 that includes study of the groups for variables and anticipated
249 outcomes over time.

250 (35) "Rescission" means a cancellation or discontinuance of coverage
251 under a health benefit plan that has a retroactive effect. "Rescission"

252 does not include a cancellation or discontinuance of coverage under a
253 health benefit plan if (A) such cancellation or discontinuance has a
254 prospective effect only, or (B) such cancellation or discontinuance is
255 effective retroactively to the extent it is attributable to the covered
256 person's failure to timely pay required premiums or contributions
257 towards the cost of such coverage.

258 (36) "Retrospective review" means any review of a request for a
259 benefit that is not a prospective review or concurrent review.
260 "Retrospective review" does not include a review of a request that is
261 limited to the veracity of documentation or the accuracy of coding.

262 (37) "Stabilize" means, with respect to an emergency medical
263 condition, that (A) no material deterioration of such condition is likely,
264 within reasonable medical probability, to result from or occur during
265 the transfer of the individual from a facility, or (B) with respect to a
266 pregnant woman, the woman has delivered, including the placenta.

267 (38) "Urgent care request" means a request for a health care service
268 or course of treatment for which the time period for making a non-
269 urgent care request determination (A) could seriously jeopardize the
270 life or health of the covered person or the ability of the covered person
271 to regain maximum function, or (B) in the opinion of a health care
272 professional with knowledge of the covered person's medical
273 condition, would subject the covered person to severe pain that cannot
274 be adequately managed without the health care service or treatment
275 being requested.

276 (39) "Utilization review" means the use of a set of formal techniques
277 designed to monitor the use of, or evaluate the medical necessity,
278 appropriateness, efficacy or efficiency of, health care services, health
279 care procedures or health care settings. Such techniques may include
280 the monitoring of or evaluation of (A) health care services performed
281 or provided in an outpatient setting, (B) the formal process for
282 determining, prior to discharge from a facility, the coordination and
283 management of the care that a patient receives following discharge

284 from a facility, (C) opportunities or requirements to obtain a clinical
285 evaluation by a health care professional other than the one originally
286 making a recommendation for a proposed health care service, (D)
287 coordinated sets of activities conducted for individual patient
288 management of serious, complicated, protracted or other health
289 conditions, or (E) prospective review, concurrent review, retrospective
290 review or certification.

291 (40) "Utilization review company" means an entity that conducts
292 utilization review.

293 Sec. 2. (NEW) (*Effective July 1, 2011*) (a) Sections 1 to 13, inclusive, of
294 this act shall apply to (1) any health carrier offering a health benefit
295 plan and that provides or performs utilization review including
296 prospective, concurrent or retrospective review benefit determinations,
297 and (2) any utilization review company or designee of a health carrier
298 that performs utilization review on the health carrier's behalf,
299 including prospective, concurrent or retrospective review benefit
300 determinations.

301 (b) Each health carrier shall be responsible for monitoring all
302 utilization review program activities carried out by or on behalf of
303 such health carrier. Such health carrier shall comply with the
304 provisions of sections 1 to 13, inclusive, of this act and any regulations
305 adopted thereunder, and shall be responsible for ensuring that any
306 utilization review company or other entity such health carrier contracts
307 with to perform utilization review complies with said sections and
308 regulations. Each health carrier shall ensure that appropriate personnel
309 have operational responsibility for the activities of the health carrier's
310 utilization review program.

311 (c) (1) A health carrier that requires utilization review of a benefit
312 request under a health benefit plan shall implement a utilization
313 review program and develop a written document that describes all
314 utilization review activities and procedures, whether or not delegated,
315 for (A) the filing of benefit requests, (B) the notification to covered

316 persons of utilization review and benefit determinations, and (C) the
317 review of adverse determinations and grievances in accordance with
318 sections 5 and 6 of this act.

319 (2) Such document shall describe the following:

320 (A) Procedures to evaluate the medical necessity, appropriateness,
321 health care setting, level of care or effectiveness of health care services;

322 (B) Data sources and clinical review criteria used in making
323 determinations;

324 (C) Procedures to ensure consistent application of clinical review
325 criteria and compatible determinations;

326 (D) Data collection processes and analytical methods used to assess
327 utilization of health care services;

328 (E) Provisions to ensure the confidentiality of clinical, proprietary
329 and protected health information;

330 (F) The health carrier's organizational mechanism, such as a
331 utilization review committee or quality assurance or other committee,
332 that periodically assesses the health carrier's utilization review
333 program and reports to the health carrier's governing body; and

334 (G) The health carrier's staff position that is responsible for the day-
335 to-day management of the utilization review program.

336 (d) Each health carrier shall:

337 (1) Include in the insurance policy, certificate of coverage or
338 handbook provided to covered persons a clear and comprehensive
339 description of:

340 (A) Its utilization review and benefit determination procedures;

341 (B) Its grievance procedures, including the grievance procedures for
342 requesting a review of an adverse determination;

343 (C) A description of the external review procedures set forth in
344 section 7 of this act, in a format prescribed by the commissioner and
345 including a statement that discloses that:

346 (i) A covered person may file a request for an external review of an
347 adverse determination or a final adverse determination with the
348 commissioner and that such review is available when the adverse
349 determination or the final adverse determination involves an issue of
350 medical necessity, appropriateness, health care setting, level of care or
351 effectiveness. Such disclosure shall include the contact information of
352 the commissioner; and

353 (ii) When filing a request for an external review of an adverse
354 determination or a final adverse determination, the covered person
355 shall be required to authorize the release of any medical records that
356 may be required to be reviewed for the purpose of making a decision
357 on such request;

358 (D) A statement of the rights and responsibilities of covered persons
359 with respect to each of the procedures under subparagraphs (A) to (C),
360 inclusive, of this subdivision. Such statement shall include a disclosure
361 that a covered person has the right to contact the commissioner's office
362 or the Office of Healthcare Advocate at any time for assistance and
363 shall include the contact information for said offices;

364 (2) Inform its covered persons, at the time of initial enrollment and
365 at least annually thereafter, of its grievance procedures. This
366 requirement may be fulfilled by including such procedures in an
367 enrollment agreement or update to such agreement;

368 (3) Inform a covered person and the covered person's health care
369 professional of the health carrier's grievance procedures whenever the
370 health carrier denies certification of a benefit requested by a covered
371 person's health care professional;

372 (4) Include in materials intended for prospective covered persons a
373 summary of its utilization review and benefit determination

374 procedures;

375 (5) Print on its membership or identification cards a toll-free
376 telephone number for utilization review and benefit determinations;

377 (6) Maintain records of all benefit requests, claims and notices
378 associated with utilization review and benefit determinations made in
379 accordance with section 4 of this act for not less than six years after
380 such requests, claims and notices were made. Each health carrier shall
381 make such records available for examination by the commissioner and
382 appropriate federal oversight agencies upon request; and

383 (7) Maintain records in accordance with section 8 of this act of all
384 grievances received. Each health carrier shall make such records
385 available for examination by covered persons, to the extent such
386 records are permitted to be disclosed by law, the commissioner and
387 appropriate federal oversight agencies upon request.

388 (e) (1) On or before March first annually, each health carrier shall
389 file with the commissioner:

390 (A) A summary report of its utilization review program activities in
391 the calendar year immediately preceding; and

392 (B) A report that includes for each type of health benefit plan
393 offered by the health carrier:

394 (i) A certificate of compliance certifying that the utilization review
395 program of the health carrier or its designee complies with all
396 applicable state and federal laws concerning confidentiality and
397 reporting requirements;

398 (ii) The number of covered lives;

399 (iii) The total number of grievances received;

400 (iv) The number of grievances resolved at each level, if applicable,
401 and their resolution;

402 (v) The number of grievances appealed to the commissioner of
403 which the health carrier has been informed;

404 (vi) The number of grievances referred to alternative dispute
405 resolution procedures or resulting in litigation; and

406 (vii) A synopsis of actions being taken to correct any problems
407 identified.

408 (2) The commissioner shall adopt regulations, in accordance with
409 chapter 54, to establish the form and content of the reports specified in
410 subdivision (1) of this subsection.

411 Sec. 3. (NEW) (*Effective July 1, 2011*) (a) (1) Each health carrier shall
412 contract with (A) health care professionals to administer such health
413 carrier's utilization review program and oversee utilization review
414 determinations, and (B) with clinical peers to evaluate the clinical
415 appropriateness of an adverse determination.

416 (2) Each utilization review program shall use documented clinical
417 review criteria that are based on sound clinical evidence and are
418 evaluated periodically by the health carrier's organizational
419 mechanism specified in subparagraph (F) of subdivision (2) of
420 subsection (c) of section 2 of this act to assure such program's ongoing
421 effectiveness. A health carrier may develop its own clinical review
422 criteria or it may purchase or license clinical review criteria from
423 qualified vendors approved by the commissioner. Each health carrier
424 shall make its clinical review criteria available upon request to
425 authorized government agencies.

426 (b) Each health carrier shall:

427 (1) Have procedures in place to ensure that the health care
428 professionals administering such health carrier's utilization review
429 program are applying the clinical review criteria consistently in
430 utilization review determinations;

431 (2) Have data systems sufficient to support utilization review

432 program activities and to generate management reports to enable the
433 health carrier to monitor and manage health care services effectively;

434 (3) Provide covered persons and participating providers with access
435 to its utilization review staff through a toll-free telephone number or
436 any other free calling option or by electronic means;

437 (4) Coordinate the utilization review program with other medical
438 management activity conducted by the health carrier, such as quality
439 assurance, credentialing, contracting with health care professionals,
440 data reporting, grievance procedures, processes for assessing member
441 satisfaction and risk management; and

442 (5) Routinely assess the effectiveness and efficiency of its utilization
443 review program.

444 (c) If a health carrier delegates any utilization review activities to a
445 utilization review company, the health carrier shall maintain adequate
446 oversight, which shall include (1) a written description of the
447 utilization review company's activities and responsibilities, including
448 such company's reporting requirements, (2) evidence of the health
449 carrier's formal approval of the utilization review company program,
450 and (3) a process by which the health carrier shall evaluate the
451 utilization review company's performance.

452 (d) When conducting utilization review, the health carrier shall (1)
453 collect only the information necessary, including pertinent clinical
454 information, to make the utilization review or benefit determination,
455 and (2) ensure that such review is conducted in a manner to ensure the
456 independence and impartiality of the individual or individuals
457 involved in making the utilization review or benefit determination. No
458 health carrier shall make decisions regarding the hiring, compensation,
459 termination, promotion or other similar matters of such individual or
460 individuals based on the likelihood that the individual or individuals
461 will support the denial of benefits.

462 Sec. 4. (NEW) (*Effective July 1, 2011*) (a) (1) Each health carrier shall

463 maintain written procedures for (A) utilization review and benefit
464 determinations, (B) expedited utilization review and benefit
465 determinations with respect to prospective urgent care requests and
466 concurrent review urgent care requests, and (C) notifying covered
467 persons or covered persons' authorized representatives of such review
468 and benefit determinations. Each health carrier shall make such review
469 and benefit determinations within the specified time periods under
470 this section.

471 (2) In determining whether a benefit request shall be considered an
472 urgent care request, an individual acting on behalf of a health carrier
473 shall apply the judgment of a prudent layperson who possesses an
474 average knowledge of health and medicine, except that any benefit
475 request determined to be an urgent care request by a health care
476 professional with knowledge of the covered person's medical
477 condition shall be deemed an urgent care request.

478 (b) With respect to a nonurgent care request:

479 (1) For a prospective or concurrent review request, a health carrier
480 shall make a determination within a reasonable period of time
481 appropriate to the covered person's medical condition, but not later
482 than fifteen calendar days after the date the health carrier receives such
483 request, and shall notify the covered person and, if applicable, the
484 covered person's authorized representative of such determination,
485 whether or not the carrier certifies the provision of the benefit.

486 (2) For a retrospective review request, a health carrier shall make a
487 determination within a reasonable period of time, but not later than
488 thirty calendar days after the date the health carrier receives such
489 request.

490 (3) The time periods specified in subdivisions (1) and (2) of this
491 subsection may be extended once by the health carrier for up to fifteen
492 calendar days, provided the health carrier:

493 (A) Determines that an extension is necessary due to circumstances

494 beyond the health carrier's control; and

495 (B) Notifies the covered person and, if applicable, the covered
496 person's authorized representative prior to the expiration of the initial
497 time period, of the circumstances requiring the extension of time and
498 the date by which the health carrier expects to make a determination.

499 (4) (A) If the extension pursuant to subdivision (3) of this subsection
500 is necessary due to the failure of the covered person or the covered
501 person's authorized representative to provide information necessary to
502 make a determination on the request, the health carrier shall:

503 (i) Specifically describe in the notice of extension the required
504 information necessary to complete the request; and

505 (ii) Provide the covered person and, if applicable, the covered
506 person's authorized representative with not less than forty-five
507 calendar days after the date of receipt of the notice to provide the
508 specified information.

509 (B) If the covered person or the covered person's authorized
510 representative fails to submit the specified information before the end
511 of the period of the extension, the health carrier may deny certification
512 of the benefit requested.

513 (c) With respect to an urgent care request:

514 (1) Unless the covered person or the covered person's authorized
515 representative has failed to provide information necessary for the
516 health carrier to make a determination, the health carrier shall make a
517 determination as soon as possible, taking into account the covered
518 person's medical condition, but not later than seventy-two hours after
519 the health carrier receives such request, provided, if the urgent care
520 request is a concurrent review request to extend a course of treatment
521 beyond the initial period of time or the number of treatments, such
522 request is made at least twenty-four hours prior to the expiration of the
523 prescribed period of time or number of treatments;

524 (2) (A) If the covered person or the covered person's authorized
525 representative has failed to provide information necessary for the
526 health carrier to make a determination, the health carrier shall notify
527 the covered person or the covered person's representative, as
528 applicable, as soon as possible, but not later than twenty-four hours
529 after the health carrier receives such request.

530 (B) The health carrier shall provide the covered person or the
531 covered person's authorized representative, as applicable, a reasonable
532 period of time to submit the specified information, taking into account
533 the covered person's medical condition, but not less than forty-eight
534 hours after notifying the covered person or the covered person's
535 authorized representative, as applicable.

536 (3) The health carrier shall notify the covered person and, if
537 applicable, the covered person's authorized representative of its
538 determination as soon as possible, but not later than forty-eight hours
539 after the earlier of (i) the date on which the covered person and the
540 covered person's authorized representative, as applicable, provides the
541 specified information to the health carrier, or (ii) the date on which the
542 specified information was to have been submitted.

543 (d) (1) Whenever a health carrier receives a review request from a
544 covered person or a covered person's authorized representative that
545 fails to meet the health carrier's filing procedures, the health carrier
546 shall notify the covered person and, if applicable, the covered person's
547 authorized representative of such failure not later than five calendar
548 days after the health carrier receives such request, except that for an
549 urgent care request, the health carrier shall notify the covered person
550 and, if applicable, the covered person's authorized representative of
551 such failure not later than twenty-four hours after the health carrier
552 receives such request.

553 (2) If the health carrier provides such notice orally, the health carrier
554 shall provide confirmation in writing to the covered person and the
555 covered person's health care professional of record not later than five

556 calendar days after providing the oral notice.

557 (e) Each health carrier shall provide promptly to a covered person
558 and, if applicable, the covered person's authorized representative a
559 notice of an adverse determination. Such notice may be provided in
560 writing or by electronic means and shall set forth, in a manner
561 calculated to be understood by the covered person or the covered
562 person's authorized representative:

563 (1) Information sufficient to identify the benefit request or claim
564 involved, including the date of service, if applicable, the health care
565 professional and the claim amount;

566 (2) The specific reason or reasons for the adverse determination and
567 a description of the health carrier's standard, if any, that was used in
568 reaching the denial;

569 (3) Reference to the specific health benefit plan provisions on which
570 the determination is based;

571 (4) A description of any additional material or information
572 necessary for the covered person to perfect the benefit request or claim,
573 including an explanation of why the material or information is
574 necessary to perfect the request or claim;

575 (5) A description of the health carrier's internal grievance process
576 that includes (A) the health carrier's expedited review procedures, (B)
577 any time limits applicable to such process or procedures, (C) the
578 contact information for the organizational unit designated to
579 coordinate the review on behalf of the health carrier, and (D) a
580 statement that the covered person or, if applicable, the covered
581 person's authorized representative is entitled, pursuant to the
582 requirements of the health carrier's internal grievance process, to (i)
583 submit written comments, documents, records and other material
584 relating to the covered person's benefit request for consideration by the
585 individual or individuals conducting the review, and (ii) receive from
586 the health carrier, free of charge upon request, reasonable access to and

587 copies of all documents, records and other information relevant to the
588 covered person's benefit request;

589 (6) If the adverse determination is based on a health carrier's
590 internal rule, guideline, protocol or other similar criterion, (A) the
591 specific rule, guideline, protocol or other similar criterion, or (B) a
592 statement that a specific rule, guideline, protocol or other similar
593 criterion of the health carrier was relied upon to make the adverse
594 determination and that a copy of such rule, guideline, protocol or other
595 similar criterion will be provided to the covered person free of charge
596 upon request, and instructions for requesting such copy;

597 (7) If the adverse determination is based on medical necessity or an
598 experimental or investigational treatment or similar exclusion or limit,
599 the written statement of the scientific or clinical rationale for the
600 adverse determination and (A) an explanation of the scientific or
601 clinical rationale used to make the determination that applies the terms
602 of the health benefit plan to the covered person's medical
603 circumstances, or (B) a statement that an explanation will be provided
604 to the covered person free of charge upon request, and instructions for
605 requesting a copy of such explanation; and

606 (8) A statement explaining the right of the covered person to contact
607 the commissioner's office or the Office of the Healthcare Advocate at
608 any time for assistance or, upon completion of the health carrier's
609 internal grievance process, to file a civil suit in a court of competent
610 jurisdiction. Such statement shall include the contact information for
611 said offices.

612 (f) If the adverse determination is a rescission, the health carrier
613 shall include with the advance notice of the application for rescission
614 required to be sent to the covered person, a written statement that
615 includes:

616 (1) Clear identification of the alleged fraudulent act, practice or
617 omission or the intentional misrepresentation of material fact;

618 (2) An explanation as to why the act, practice or omission was
619 fraudulent or was an intentional misrepresentation of a material fact;

620 (3) A disclosure that the covered person or the covered person's
621 authorized representative may file immediately, without waiting for
622 the date such advance notice of the proposed rescission ends, a
623 grievance with the health carrier to request a review of the adverse
624 determination to rescind coverage, pursuant to sections 5 and 6 of this
625 act;

626 (4) A description of the health carrier's grievance procedures
627 established under sections 5 and 6 of this act, including any time limits
628 applicable to those procedures; and

629 (5) The date such advance notice of the proposed rescission ends
630 and the date back to which the coverage will be retroactively
631 rescinded.

632 (g) (1) Whenever a health carrier fails to strictly adhere to the
633 requirements of this section with respect to making utilization review
634 and benefit determinations of a benefit request or claim, the covered
635 person shall be deemed to have exhausted the internal grievance
636 process of such health carrier and may file a request for an external
637 review in accordance with the provisions of section 7 of this act,
638 regardless of whether the health carrier asserts it substantially
639 complied with the requirements of this section or that any error it
640 committed was de minimis.

641 (2) A covered person who has exhausted the internal grievance
642 process of a health carrier may, in addition to filing a request for an
643 external review, pursue any available remedies under state or federal
644 law on the basis that the health carrier failed to provide a reasonable
645 internal grievance process that would yield a decision on the merits of
646 the claim.

647 Sec. 5. (NEW) (*Effective July 1, 2011*) (a) (1) Each health carrier shall
648 establish and maintain written procedures for (A) the review of

649 grievances of adverse determinations that were based, in whole or in
650 part, on medical necessity, (B) the expedited review of grievances of
651 adverse determinations of urgent care requests, including concurrent
652 review urgent care requests involving an admission, availability of
653 care, continued stay or health care service for a covered person who
654 has received emergency services but has not been discharged from a
655 facility, and (C) notifying covered persons or covered persons'
656 authorized representatives of such adverse determinations.

657 (2) Each health carrier shall file with the commissioner a copy of
658 such procedures, including all forms used to process requests, and any
659 subsequent material modifications to such procedures.

660 (3) In addition to a copy of such procedures, each health carrier shall
661 file annually with the commissioner, as part of its annual report
662 required under subsection (e) of section 2 of this act, a certificate of
663 compliance stating that the health carrier has established and
664 maintains grievance procedures for each of its health benefit plans that
665 are fully compliant with the provisions of sections 1 to 13, inclusive, of
666 this act.

667 (b) (1) A covered person or a covered person's authorized
668 representative may file a grievance of an adverse determination that
669 was based, in whole or in part, on medical necessity with the health
670 carrier not later than one hundred eighty calendar days after the
671 covered person or the covered person's authorized representative, as
672 applicable, receives the notice of an adverse determination.

673 (2) For prospective or concurrent urgent care requests, a covered
674 person or a covered person's authorized representative may make a
675 request for an expedited review orally or in writing.

676 (c) (1) (A) When conducting a review of an adverse determination
677 under this section, the health carrier shall ensure that such review is
678 conducted in a manner to ensure the independence and impartiality of
679 the individual or individuals involved in making the review decision.

680 (B) If the adverse determination involves utilization review, the
681 health carrier shall designate an appropriate clinical peer or peers to
682 review such adverse determination. Such clinical peer or peers shall
683 not have been involved in the initial adverse determination.

684 (C) The individual or individuals conducting a review under this
685 section shall take into consideration all comments, documents, records
686 and other information relevant to the covered person's benefit request
687 that is the subject of the adverse determination under review, that are
688 submitted by the covered person or the covered person's authorized
689 representative, regardless of whether such information was submitted
690 or considered in making the initial adverse determination.

691 (D) Prior to issuing a decision, the health carrier shall provide free
692 of charge to the covered person or the covered person's authorized
693 representative, as applicable, any new or additional evidence relied
694 upon and any new or additional scientific or clinical rationale used by
695 the health carrier in connection with the grievance. Such evidence and
696 rationale shall be provided sufficiently in advance of the date the
697 health carrier is required to issue a decision to permit the covered
698 person or the covered person's authorized representative, as
699 applicable, a reasonable opportunity to respond prior to such date.

700 (2) If the review under subdivision (1) of this subsection is an
701 expedited review, all necessary information, including the health
702 carrier's decision, shall be transmitted between the health carrier and
703 the covered person or the covered person's authorized representative,
704 as applicable, by telephone, facsimile, electronic means or any other
705 expeditious method available.

706 (3) If the review under subdivision (1) of this subsection is an
707 expedited review of a grievance involving an adverse determination of
708 a concurrent review urgent care request, the treatment shall be
709 continued without liability to the covered person until the covered
710 person has been notified of the review decision.

711 (d) (1) The health carrier shall notify the covered person and, if

712 applicable, the covered person's authorized representative, in writing
713 or by electronic means, of its decision within a reasonable period of
714 time appropriate to the covered person's medical condition, but not
715 later than:

716 (A) For prospective review and concurrent review requests, thirty
717 calendar days after the health carrier receives the grievance;

718 (B) For retrospective review requests, sixty calendar days after the
719 health carrier receives the grievance; and

720 (C) For expedited review requests, seventy-two hours after the
721 health carrier receives the grievance.

722 (2) The time periods set forth in subdivision (1) of this subsection
723 shall apply regardless of whether all of the information necessary to
724 make a decision accompanies the filing.

725 (e) The notice required under subsection (d) of this section shall set
726 forth, in a manner calculated to be understood by the covered person
727 or the covered person's authorized representative:

728 (1) The titles and qualifying credentials of the individual or
729 individuals participating in the review process;

730 (2) Information sufficient to identify the claim involved with respect
731 to the grievance, including the date of service, if applicable, the health
732 care professional and the claim amount;

733 (3) A statement of such individual's or individuals' understanding
734 of the covered person's grievance;

735 (4) The individual's or individuals' decision in clear terms and the
736 health benefit plan contract basis or scientific or clinical rationale for
737 such decision in sufficient detail for the covered person to respond
738 further to the health carrier's position;

739 (5) Reference to the evidence or documentation used as the basis for

740 the decision;

741 (6) For a decision that upholds the adverse determination:

742 (A) The specific reason or reasons for the final adverse
743 determination, including the denial code and its corresponding
744 meaning, as well as a description of the health carrier's standard, if
745 any, that was used in reaching the denial;

746 (B) Reference to the specific health benefit plan provisions on which
747 the decision is based;

748 (C) A statement that the covered person may receive from the health
749 carrier, free of charge and upon request, reasonable access to and
750 copies of, all documents, records and other information relevant to the
751 adverse determination under review;

752 (D) If the final adverse determination is based on a health carrier's
753 internal rule, guideline, protocol or other similar criterion, (i) the
754 specific rule, guideline, protocol or other similar criterion, or (ii) a
755 statement that a specific rule, guideline, protocol or other similar
756 criterion of the health carrier was relied upon to make the final adverse
757 determination and that a copy of such rule, guideline, protocol or other
758 similar criterion will be provided to the covered person free of charge
759 upon request and instructions for requesting such copy;

760 (E) If the final adverse determination is based on medical necessity
761 or an experimental or investigational treatment or similar exclusion or
762 limit, the written statement of the scientific or clinical rationale for the
763 final adverse determination and (i) an explanation of the scientific or
764 clinical rationale used to make the determination that applies the terms
765 of the health benefit plan to the covered person's medical
766 circumstances, or (ii) a statement that an explanation will be provided
767 to the covered person free of charge upon request and instructions for
768 requesting a copy of such explanation;

769 (F) A statement describing the procedures for obtaining an external

770 review of the final adverse determination;

771 (7) If applicable, the following statement: "You and your plan may
772 have other voluntary alternative dispute resolution options such as
773 mediation. One way to find out what may be available is to contact
774 your state Insurance Commissioner."; and

775 (8) A statement disclosing the covered person's right to contact the
776 commissioner's office or the Office of the Healthcare Advocate at any
777 time. Such disclosure shall include the contact information for said
778 offices.

779 (f) (1) Whenever a health carrier fails to strictly adhere to the
780 requirements of this section with respect to receiving and resolving
781 grievances involving an adverse determination, the covered person
782 shall be deemed to have exhausted the internal grievance process of
783 such health carrier and may file a request for an external review,
784 regardless of whether the health carrier asserts that it substantially
785 complied with the requirements of this section, or that any error it
786 committed was de minimis.

787 (2) A covered person who has exhausted the internal grievance
788 process of a health carrier may, in addition to filing a request for an
789 external review, pursue any available remedies under state or federal
790 law on the basis that the health carrier failed to provide a reasonable
791 internal grievance process that would yield a decision on the merits of
792 the claim.

793 Sec. 6. (NEW) (*Effective July 1, 2011*) (a) Each health carrier shall
794 establish and maintain written procedures (1) for the review of
795 grievances of adverse determinations that were not based on medical
796 necessity, and (2) notifying covered persons or covered persons'
797 authorized representatives of such adverse determinations.

798 (b) (1) A covered person or the covered person's authorized
799 representative may file a grievance of an adverse determination that
800 was not based on medical necessity with the health carrier not later

801 than one hundred eighty calendar days after the covered person or the
802 covered person's representative, as applicable, receives the notice of an
803 adverse determination.

804 (2) The health carrier shall notify the covered person and, if
805 applicable, the covered person's authorized representative not later
806 than three business days after the health carrier receives a grievance
807 that the covered person or the covered person's authorized
808 representative, as applicable, is entitled to submit written material to
809 the health carrier to be considered when conducting a review of the
810 grievance.

811 (3) (A) Upon receipt of a grievance, a health carrier shall designate
812 an individual or individuals to conduct a review of the grievance.

813 (B) The health carrier shall not designate the same individual or
814 individuals who denied the claim or handled the matter that is the
815 subject of the grievance to conduct the review of the grievance.

816 (C) The health carrier shall provide the covered person and, if
817 applicable, the covered person's authorized representative with the
818 name, address and telephone number of the individual or the
819 organizational unit designated to coordinate the review on behalf of
820 the health carrier.

821 (c) (1) The health carrier shall notify the covered person and, if
822 applicable, the covered person's authorized representative in writing,
823 of its decision not later than twenty business days after the health
824 carrier received the grievance.

825 (2) If the health carrier is unable to comply with the time period
826 specified in subdivision (1) of this subsection due to circumstances
827 beyond the health carrier's control, the time period may be extended
828 by the health carrier for up to ten business days, provided that on or
829 before the twentieth business day after the health carrier received the
830 grievance, the health carrier provides written notice to the covered
831 person and, if applicable, the covered person's authorized

832 representative of the extension and the reasons for the delay.

833 (d) The written decision issued pursuant to subsection (c) of this
834 section shall contain:

835 (1) The titles and qualifying credentials of the individual or
836 individuals participating in the review process;

837 (2) A statement of such individual's or individuals' understanding
838 of the covered person's grievance;

839 (3) The individual's or individuals' decision in clear terms and the
840 health benefit plan contract basis for such decision in sufficient detail
841 for the covered person to respond further to the health carrier's
842 position; and

843 (4) Reference to the evidence or documentation used as the basis for
844 the decision.

845 Sec. 7. (NEW) (*Effective July 1, 2011*) (a) (1) A covered person or a
846 covered person's authorized representative may file a request for an
847 external review or an expedited external review of an adverse
848 determination or a final adverse determination in accordance with the
849 provisions of this section. All requests for external review or expedited
850 external review shall be made in writing to the commissioner. The
851 commissioner may prescribe the form and content of such requests.

852 (2) (A) All requests for external review or expedited external review
853 shall be accompanied by a filing fee of twenty-five dollars, except that
854 no covered person or covered person's authorized representative shall
855 pay more than seventy-five dollars in a calendar year for such covered
856 person. Any filing fee paid by a covered person's authorized
857 representative shall be deemed to have been paid by the covered
858 person. If the commissioner finds that the covered person is indigent
859 or unable to pay the filing fee, the commissioner shall waive such fee.
860 Any such fees shall be deposited in the Insurance Fund established
861 under section 38a-52a of the general statutes.

862 (B) The commissioner shall refund any paid filing fee to the covered
863 person or the covered person's authorized representative, as
864 applicable, or the health care professional if the adverse determination
865 or the final adverse determination that is the subject of the external
866 review request or expedited external review request is reversed or
867 revised.

868 (3) The health carrier that issued the adverse determination or the
869 final adverse determination that is the subject of the external review
870 request or the expedited external review request shall pay the
871 independent review organization for the cost of conducting the review.

872 (4) An external review decision, whether such review is a standard
873 external review or an expedited external review, shall be binding on
874 the health carrier or a self-insured governmental plan and the covered
875 person, except to the extent such health carrier or covered person has
876 other remedies available under federal or state law. A covered person
877 or a covered person's authorized representative shall not file a
878 subsequent request for an external review or an expedited external
879 review that involves the same adverse determination or final adverse
880 determination for which the covered person or the covered person's
881 authorized representative already received an external review decision
882 or an expedited external review decision.

883 (5) Each health carrier shall maintain written records of external
884 reviews as set forth in section 8 of this act.

885 (6) Each independent review organization shall maintain written
886 records as set forth in subsection (e) of section 13 of this act.

887 (b) (1) Except as otherwise provided under subdivision (2) of this
888 subsection or subsection (d) of this section, a covered person or a
889 covered person's authorized representative shall not file a request for
890 an external review or an expedited external review until the covered
891 person or the covered person's authorized representative has
892 exhausted the health carrier's internal grievance process.

893 (2) A health carrier may waive its internal grievance process and the
894 requirement for a covered person to exhaust such process prior to
895 filing a request for an external review or an expedited external review.

896 (c) (1) At the same time a health carrier sends to a covered person or
897 a covered person's authorized representative a written notice of an
898 adverse determination or a final adverse determination issued by the
899 health carrier, the health carrier shall include a written disclosure to
900 the covered person and, if applicable, the covered person's authorized
901 representative of the covered person's right to request an external
902 review.

903 (2) The written notice shall include:

904 (A) The following statement or a statement in substantially similar
905 language: "We have denied your request for benefit approval for a
906 health care service or course of treatment. You may have the right to
907 have our decision reviewed by health care professionals who have no
908 association with us by submitting a request for external review to the
909 office of the Insurance Commissioner, if our decision involved making
910 a judgment as to the medical necessity, appropriateness, health care
911 setting, level of care or effectiveness of the health care service or
912 treatment you requested.";

913 (B) For a notice related to an adverse determination, a statement
914 informing the covered person that:

915 (i) If the covered person has a medical condition for which the time
916 period for completion of an expedited internal review of a grievance
917 involving an adverse determination would seriously jeopardize the life
918 or health of the covered person or would jeopardize the covered
919 person's ability to regain maximum function, the covered person or the
920 covered person's authorized representative may (I) file a request for an
921 expedited external review, or (II) file a request for an expedited
922 external review if the adverse determination involves a denial of
923 coverage based on a determination that the recommended or
924 requested health care service or treatment is experimental or

925 investigational and the covered person's treating health care
926 professional certifies in writing that such recommended or requested
927 health care service or treatment would be significantly less effective if
928 not promptly initiated; and

929 (ii) Such request for expedited external review may be filed at the
930 same time the covered person or the covered person's authorized
931 representative files a request for an expedited internal review of a
932 grievance involving an adverse determination, except that the
933 independent review organization assigned to conduct the expedited
934 external review shall determine whether the covered person shall be
935 required to complete the expedited internal review of the grievance
936 prior to conducting the expedited external review;

937 (C) For a notice related to a final adverse determination, a statement
938 informing the covered person that:

939 (i) If the covered person has a medical condition for which the time
940 period for completion of an external review would seriously
941 jeopardize the life or health of the covered person or would jeopardize
942 the covered person's ability to regain maximum function, the covered
943 person or the covered person's authorized representative may file a
944 request for an expedited external review; or

945 (ii) If the final adverse determination concerns (I) an admission,
946 availability of care, continued stay or health care service for which the
947 covered person received emergency services but has not been
948 discharged from a facility, the covered person or the covered person's
949 authorized representative may file a request for an expedited external
950 review, or (II) a denial of coverage based on a determination that the
951 recommended or requested health care service or treatment is
952 experimental or investigational and the covered person's treating
953 health care professional certifies in writing that such recommended or
954 requested health care service or treatment would be significantly less
955 effective if not promptly initiated, the covered person or the covered
956 person's authorized representative may file a request for an expedited

957 external review;

958 (D) (i) A copy of the description of both the standard and expedited
959 external review procedures the health carrier is required to provide,
960 highlighting the provisions in the external review procedures that give
961 the covered person or the covered person's authorized representative
962 the opportunity to submit additional information and including any
963 forms used to process an external review or an expedited external
964 review;

965 (ii) As part of any forms provided under subparagraph (D)(i) of this
966 subdivision, an authorization form or other document approved by the
967 commissioner that complies with the requirements of 45 CFR 164.508,
968 as amended from time to time, by which the covered person shall
969 authorize the health carrier and the covered person's treating health
970 care professional to release, transfer or otherwise divulge, in
971 accordance with sections 38a-975 to 38a-999a, inclusive, of the general
972 statutes, the covered person's protected health information including
973 medical records for purposes of conducting an external review or an
974 expedited external review.

975 (d) (1) A covered person or a covered person's authorized
976 representative may file a request for an expedited external review of an
977 adverse determination or a final adverse determination with the
978 commissioner, except that an expedited external review shall not be
979 provided for a retrospective review request of an adverse
980 determination or a final adverse determination.

981 (2) Such request may be filed at the time the covered person
982 receives:

983 (A) An adverse determination, if:

984 (i) (I) The covered person has a medical condition for which the time
985 period for completion of an expedited internal review of the adverse
986 determination would seriously jeopardize the life or health of the
987 covered person or would jeopardize the covered person's ability to

988 regain maximum function; or

989 (II) The denial of coverage is based on a determination that the
990 recommended or requested health care service or treatment is
991 experimental or investigational and the covered person's treating
992 health care professional certifies in writing that such recommended or
993 requested health care service or treatment would be significantly less
994 effective if not promptly initiated; and

995 (ii) The covered person or the covered person's authorized
996 representative has filed a request for an expedited internal review of
997 the adverse determination; or

998 (B) A final adverse determination if:

999 (i) The covered person has a medical condition where the time
1000 period for completion of a standard external review would seriously
1001 jeopardize the life or health of the covered person or would jeopardize
1002 the covered person's ability to regain maximum function;

1003 (ii) The final adverse determination concerns an admission,
1004 availability of care, continued stay or health care service for which the
1005 covered person received emergency services but has not been
1006 discharged from a facility; or

1007 (iii) The denial of coverage is based on a determination that the
1008 recommended or requested health care service or treatment is
1009 experimental or investigational and the covered person's treating
1010 health care professional certifies in writing that such recommended or
1011 requested health care service or treatment would be significantly less
1012 effective if not promptly initiated.

1013 (3) Such covered person or covered person's authorized
1014 representative shall not be required to file a request for an external
1015 review prior to, or at the same time as, the filing of a request for an
1016 expedited external review and shall not be precluded from filing a
1017 request for an external review, within the time periods set forth in

1018 subsection (e) of this section, if the request for an expedited external
1019 review is determined to be ineligible for such review.

1020 (e) (1) Not later than one hundred twenty calendar days after a
1021 covered person or a covered person's authorized representative
1022 receives a notice of an adverse determination or a final adverse
1023 determination, the covered person or the covered person's authorized
1024 representative may file a request for an external review or an
1025 expedited external review with the commissioner in accordance with
1026 this section.

1027 (2) Not later than one business day after the commissioner receives
1028 a request that is complete, the commissioner shall send a copy of such
1029 request to the health carrier that issued the adverse determination or
1030 the final adverse determination that is the subject of the request.

1031 (3) Not later than (A) five business days after the health carrier
1032 receives the copy of an external review request, or (B) one calendar day
1033 after the health carrier receives the copy of an expedited external
1034 review request, from the commissioner, the health carrier shall
1035 complete a preliminary review of the request to determine whether:

1036 (A) The individual is or was a covered person under the health
1037 benefit plan at the time the health care service was requested or, in the
1038 case of an external review of a retrospective review request, was a
1039 covered person in the health benefit plan at the time the health care
1040 service was provided;

1041 (B) The health care service that is the subject of the adverse
1042 determination or the final adverse determination is a covered service
1043 under the covered person's health benefit plan but for the health
1044 carrier's determination that the health care service is not covered
1045 because it does not meet the health carrier's requirements for medical
1046 necessity, appropriateness, health care setting, level of care or
1047 effectiveness;

1048 (C) If the health care service or treatment is experimental or

1049 investigational:

1050 (i) Is a covered benefit under the covered person's health benefit
1051 plan but for the health carrier's determination that the service or
1052 treatment is experimental or investigational for a particular medical
1053 condition;

1054 (ii) Is not explicitly listed as an excluded benefit under the covered
1055 person's health benefit plan;

1056 (iii) The covered person's treating health care professional has
1057 certified that one of the following situations is applicable:

1058 (I) Standard health care services or treatments have not been
1059 effective in improving the medical condition of the covered person;

1060 (II) Standard health care services or treatments are not medically
1061 appropriate for the covered person; or

1062 (III) There is no available standard health care service or treatment
1063 covered by the health carrier that is more beneficial than the
1064 recommended or requested health care service or treatment; and

1065 (iv) The covered person's treating health care professional:

1066 (I) Has recommended a health care service or treatment that the
1067 health care professional certifies, in writing, is likely to be more
1068 beneficial to the covered person, in the health care professional's
1069 opinion, than any available standard health care services or treatments;
1070 or

1071 (II) Is a licensed, board certified or board eligible health care
1072 professional qualified to practice in the area of medicine appropriate to
1073 treat the covered person's condition and has certified in writing that
1074 scientifically valid studies using accepted protocols demonstrate that
1075 the health care service or treatment requested by the covered person
1076 that is the subject of the adverse determination or the final adverse
1077 determination is likely to be more beneficial to the covered person than

1078 any available standard health care services or treatments;

1079 (D) The covered person has exhausted the health carrier's internal
1080 grievance process or the covered person or the covered person's
1081 authorized representative has filed a request for an expedited external
1082 review as provided under subsection (d) of this section; and

1083 (E) The covered person has provided all the information and forms
1084 required to process an external review or an expedited external review,
1085 including an authorization form as set forth in subparagraph (D)(ii) of
1086 subdivision (2) of subsection (c) of this section.

1087 (4) (A) Not later than (i) one business day after the preliminary
1088 review of an external review request, or (ii) the day the preliminary
1089 review of an expedited external review request is completed, the
1090 health carrier shall notify the commissioner, the covered person and, if
1091 applicable, the covered person's authorized representative in writing
1092 whether the request for an external review or an expedited external
1093 review is complete and eligible for such review. The commissioner
1094 may specify the form for the health carrier's notice of initial
1095 determination under this subdivision and any supporting information
1096 required to be included in the notice.

1097 (B) If the request:

1098 (i) Is not complete, the health carrier shall notify the commissioner
1099 and the covered person and, if applicable, the covered person's
1100 authorized representative in writing and include in the notice what
1101 information or materials are needed to perfect the request; or

1102 (ii) Is not eligible for external review or expedited external review,
1103 the health carrier shall notify the commissioner, the covered person
1104 and, if applicable, the covered person's authorized representative in
1105 writing and include in the notice the reasons for its ineligibility.

1106 (C) The notice of initial determination shall include a statement
1107 informing the covered person and, if applicable, the covered person's

1108 authorized representative that a health carrier's initial determination
1109 that the request for an external review or an expedited external review
1110 is ineligible for review may be appealed to the commissioner.

1111 (D) Notwithstanding a health carrier's initial determination that a
1112 request for an external review or an expedited external review is
1113 ineligible for review, the commissioner may determine, pursuant to
1114 the terms of the covered person's health benefit plan, that such request
1115 is eligible for such review and assign an independent review
1116 organization to conduct such review. Any such review shall be
1117 conducted in accordance with this section.

1118 (f) (1) Whenever the commissioner is notified pursuant to
1119 subparagraph (A) of subdivision (4) of subsection (e) of this section
1120 that a request is eligible for external review or expedited external
1121 review, the commissioner shall, not later than (A) one business day
1122 after receiving such notice for an external review, or (B) one calendar
1123 day after receiving such notice for an expedited external review:

1124 (i) Assign an independent review organization from the list of
1125 approved independent review organizations compiled and maintained
1126 by the commissioner pursuant to section 12 of this act to conduct the
1127 review and notify the health carrier of the name of the assigned
1128 independent review organization. Such assignment shall be done on a
1129 random basis among those approved independent review
1130 organizations qualified to conduct the particular review based on the
1131 nature of the health care service that is the subject of the adverse
1132 determination or the final adverse determination and other
1133 circumstances, including conflict of interest concerns as set forth in
1134 section 13 of this act; and

1135 (ii) Notify the covered person and, if applicable, the covered
1136 person's authorized representative in writing of the request's eligibility
1137 and acceptance for external review or expedited external review. For
1138 an external review, the commissioner shall include in such notice (I) a
1139 statement that the covered person or the covered person's authorized

1140 representative may submit, not later than five business days after the
1141 covered person or the covered person's authorized representative, as
1142 applicable, received such notice, additional information in writing to
1143 the assigned independent review organization that such organization
1144 shall consider when conducting the external review, and (II) where
1145 and how such additional information is to be submitted. If additional
1146 information is submitted later than five business days after the covered
1147 person or the covered person's authorized representative, as
1148 applicable, received such notice, the independent review organization
1149 may, but shall not be required to, accept and consider such additional
1150 information.

1151 (2) Not later than (A) five business days for an external review, or
1152 (B) one calendar day for an expedited external review, after the health
1153 carrier receives notice of the name of the assigned independent review
1154 organization from the commissioner, the health carrier or its designee
1155 utilization review company shall provide to the assigned independent
1156 review organization the documents and any information such health
1157 carrier or utilization review company considered in making the
1158 adverse determination or the final adverse determination.

1159 (3) The failure of the health carrier or its designee utilization review
1160 company to provide the documents and information within the time
1161 specified in subdivision (2) of this subsection shall not delay the
1162 conducting of the review.

1163 (4) (i) If the health carrier or its designee utilization review company
1164 fails to provide the documents and information within the time period
1165 specified in subdivision (2) of this subsection, the independent review
1166 organization may terminate the review and make a decision to reverse
1167 the adverse determination or the final adverse determination.

1168 (ii) Not later than one business day after terminating the review and
1169 making the decision to reverse the adverse determination or the final
1170 adverse determination, the independent review organization shall
1171 notify the commissioner, the health carrier, the covered person and, if

1172 applicable, the covered person's authorized representative in writing
1173 of such decision.

1174 (g) (1) The assigned independent review organization shall review
1175 all the information and documents received pursuant to subsection (f)
1176 of this section. In reaching a decision, the independent review
1177 organization shall not be bound by any decisions or conclusions
1178 reached during the health carrier's utilization review process.

1179 (2) Not later than one business day after receiving any information
1180 submitted by the covered person or the covered person's authorized
1181 representative pursuant to subparagraph (B) of subdivision (1) of
1182 subsection (f) of this section, the independent review organization
1183 shall forward such information to the health carrier.

1184 (3) (A) Upon the receipt of any information forwarded pursuant to
1185 subdivision (2) of this subsection, the health carrier may reconsider its
1186 adverse determination or the final adverse determination that is the
1187 subject of the review. Such reconsideration shall not delay or terminate
1188 the review.

1189 (B) The independent review organization shall terminate the review
1190 if the health carrier decides, upon completion of its reconsideration
1191 and notice to such organization as provided in subparagraph (C) of
1192 this subdivision, to reverse its adverse determination or its final
1193 adverse determination and provide coverage or payment for the health
1194 care service or treatment that is the subject of the adverse
1195 determination or the final adverse determination.

1196 (C) Not later than one business day after making the decision to
1197 reverse its adverse determination or its final adverse determination,
1198 the health carrier shall notify the commissioner, the assigned
1199 independent review organization, the covered person and, if
1200 applicable, the covered person's authorized representative in writing
1201 of such decision.

1202 (h) In addition to the documents and information received pursuant

1203 to subsection (f) of this section, the independent review organization
1204 shall consider, to the extent the documents or information are available
1205 and the independent review organization considers them appropriate,
1206 the following in reaching a decision:

1207 (1) The covered person's medical records;

1208 (2) The attending health care professional's recommendation;

1209 (3) Consulting reports from appropriate health care professionals
1210 and other documents submitted by the health carrier, the covered
1211 person, the covered person's authorized representative or the covered
1212 person's treating health care professional;

1213 (4) The terms of coverage under the covered person's health benefit
1214 plan to ensure that the independent review organization's decision is
1215 not contrary to the terms of coverage under such health benefit plan;

1216 (5) The most appropriate practice guidelines, which shall include
1217 applicable evidence-based standards and may include any other
1218 practice guidelines developed by the federal government, national or
1219 professional medical societies, medical boards or medical associations;

1220 (6) Any applicable clinical review criteria developed and used by
1221 the health carrier or its designee utilization review company; and

1222 (7) The opinion or opinions of the independent review
1223 organization's clinical peer or peers who conducted the review after
1224 considering subdivisions (1) to (6), inclusive, of this subsection.

1225 (i) (1) The independent review organization shall notify the
1226 commissioner, the health carrier, the covered person and, if applicable,
1227 the covered person's authorized representative in writing of its
1228 decision to uphold, reverse or revise the adverse determination or the
1229 final adverse determination, not later than:

1230 (A) For external reviews, forty-five calendar days after such
1231 organization receives the assignment from the commissioner to

1232 conduct such review;

1233 (B) For external reviews involving a determination that the
1234 recommended or requested health care service or treatment is
1235 experimental or investigational, twenty calendar days after such
1236 organization receives the assignment from the commissioner to
1237 conduct such review;

1238 (C) For expedited external reviews, as expeditiously as the covered
1239 person's medical condition requires, but not later than seventy-two
1240 hours after such organization receives the assignment from the
1241 commissioner to conduct such review; and

1242 (D) For expedited external reviews involving a determination that
1243 the recommended or requested health care service or treatment is
1244 experimental or investigational, as expeditiously as the covered
1245 person's medical condition requires, but not later than five calendar
1246 days after such organization receives the assignment from the
1247 commissioner to conduct such review.

1248 (2) Such notice shall include:

1249 (A) A general description of the reason for the request for the
1250 review;

1251 (B) The date the independent review organization received the
1252 assignment from the commissioner to conduct the review;

1253 (C) The date the review was conducted;

1254 (D) The date the organization made its decision;

1255 (E) The principal reason or reasons for its decision, including what
1256 applicable evidence-based standards, if any, were used as a basis for its
1257 decision;

1258 (F) The rationale for the organization's decision;

1259 (G) Reference to the evidence or documentation, including any

1260 evidence-based standards, considered by the organization in reaching
1261 its decision; and

1262 (H) For a review involving a determination that the recommended
1263 or requested health care service or treatment is experimental or
1264 investigational:

1265 (i) A description of the covered person's medical condition;

1266 (ii) A description of the indicators relevant to determining whether
1267 there is sufficient evidence to demonstrate that (I) the recommended or
1268 requested health care service or treatment is likely to be more
1269 beneficial to the covered person than any available standard health
1270 care services or treatments, and (II) the adverse risks of the
1271 recommended or requested health care service or treatment would not
1272 be substantially increased over those of available standard health care
1273 services or treatments;

1274 (iii) A description and analysis of any medical or scientific evidence
1275 considered in reaching the opinion;

1276 (iv) A description and analysis of any evidence-based standard; and

1277 (v) Information on whether the clinical peer's rationale for the
1278 opinion is based on the documents and information set forth in
1279 subsection (f) of this section.

1280 (3) Upon the receipt of a notice of the independent review
1281 organization's decision to reverse or revise an adverse determination
1282 or a final adverse determination, the health carrier shall immediately
1283 approve the coverage that was the subject of the adverse determination
1284 or the final adverse determination.

1285 Sec. 8. (NEW) (*Effective July 1, 2011*) (a) (1) Each health carrier shall
1286 maintain written records to document all grievances of adverse
1287 determinations it receives, including the notices and claims associated
1288 with such grievances, during a calendar year.

1289 (2) (A) Each health carrier shall maintain such records for not less
1290 than six years after the notice of an adverse determination that is the
1291 subject of a grievance was provided to a covered person or the covered
1292 person's authorized representative, as applicable, under section 4 of
1293 this act.

1294 (B) The health carrier shall make such records available for
1295 examination by covered persons, to the extent such records are
1296 permitted to be disclosed by law, the commissioner and appropriate
1297 federal oversight agencies upon request. Such records shall be
1298 maintained in a manner that is reasonably clear and accessible to the
1299 commissioner.

1300 (b) For each grievance the record shall contain, at a minimum, the
1301 following information: (1) A general description of the reason for the
1302 grievance; (2) the date the health carrier received the grievance; (3) the
1303 date of each review or, if applicable, review meeting of the grievance;
1304 (4) the resolution at each level of the grievance, if applicable; (5) the
1305 date of resolution at each such level, if applicable; and (6) the name of
1306 the covered person for whom the grievance was filed.

1307 (c) Each health carrier shall submit a report annually to the
1308 commissioner, in accordance with section 2 of this act, of the
1309 grievances it received.

1310 (d) (1) Each health carrier shall maintain written records of all
1311 requests for external reviews, whether such requests are for standard
1312 or expedited external reviews, that such health carrier receives notice
1313 of from the commissioner in a calendar year. The health carrier shall
1314 maintain such records in the aggregate by state where the covered
1315 person requesting such review resides and by each type of health
1316 benefit plan offered by the health carrier, and shall submit a report to
1317 the commissioner upon request, in a format prescribed by the
1318 commissioner.

1319 (2) Such report shall include, in the aggregate by state where the
1320 covered person requesting such review resides and by each type of

1321 health benefit plan:

1322 (A) The total number of requests for an external review, whether
1323 such requests were for a standard or expedited external review;

1324 (B) From the total number of such requests reported under
1325 subparagraph (A) of this subdivision, the number of requests
1326 determined eligible for a full external review, whether such requests
1327 were for a standard or expedited external review; and

1328 (C) Any other information the commissioner may request or
1329 require.

1330 (3) The health carrier shall retain the written records required
1331 pursuant to subdivision (1) of this subsection for not less than six years
1332 after the request for an external review or an expedited external review
1333 was received.

1334 Sec. 9. (NEW) (*Effective July 1, 2011*) The commissioner shall adopt
1335 regulations, in accordance with chapter 54 of the general statutes, to
1336 implement the provisions of sections 1 to 8, inclusive, of this act.

1337 Sec. 10. (NEW) (*Effective July 1, 2011*) (a) No utilization review
1338 company shall conduct utilization review in this state for a health
1339 benefit plan under the jurisdiction of the commissioner unless it is
1340 licensed by the commissioner. All licenses shall be renewed on an
1341 annual basis.

1342 (b) The annual license fee shall be three thousand dollars and shall
1343 be dedicated to the regulation of utilization review, except that the
1344 commissioner shall be authorized to use such funds as is necessary to
1345 (1) implement the provisions of sections 38a-91aa to 38a-91qq,
1346 inclusive, of the general statutes, and (2) contract with The University
1347 of Connecticut School of Medicine to provide any medical
1348 consultations necessary to carry out the commissioner's responsibilities
1349 under this title with respect to consumer and market conduct matters.

1350 (c) The request for licensure or renewal shall include the name,

1351 address, telephone number and normal business hours of the
1352 utilization review company, the name and telephone number of a
1353 person for the commissioner to contact. Any material changes in the
1354 information filed in accordance with this subsection shall be filed with
1355 the commissioner not later than thirty calendar days after the change.

1356 (d) The commissioner shall receive and investigate all grievances
1357 filed against utilization review companies by a covered person. The
1358 commissioner shall code, track and review all grievances. The
1359 commissioner may impose such penalties as authorized, in accordance
1360 with section 11 of this act.

1361 (e) In the absence of any contractual agreement to the contrary, the
1362 covered person or the covered person's authorized representative shall
1363 be responsible for requesting certification and for authorizing the
1364 covered person's treating health care professional to release, in a timely
1365 manner, all information necessary to conduct the review. A utilization
1366 review company shall permit the covered person, the covered person's
1367 authorized representative or the covered person's treating health care
1368 professional to assist in fulfilling that responsibility.

1369 Sec. 11. (NEW) (*Effective July 1, 2011*) (a) Whenever the
1370 commissioner has reason to believe that a utilization review company
1371 subject to sections 1 to 10, inclusive, of this act has been or is engaging
1372 in conduct in violation of said sections, and that a proceeding by the
1373 commissioner would be in the interest of the public, the commissioner
1374 shall issue and serve upon such company a statement of the charges in
1375 that respect and a notice of a hearing to be held at a time and place
1376 fixed in the notice, which shall not be less than thirty calendar days
1377 after the date of service. At the time and place fixed for such hearing,
1378 such company shall have an opportunity to be heard and to show
1379 cause why an order should not be made by the commissioner
1380 requiring such company to cease and desist from the alleged conduct
1381 complained of.

1382 (b) If, after such hearing, the commissioner determines that the

1383 utilization review company charged has engaged in a violation of
1384 section 4 of this act, the commissioner shall reduce the findings to
1385 writing and shall issue and cause to be served upon the utilization
1386 review company a copy of such findings and an order requiring such
1387 company to cease and desist from engaging in such violation. The
1388 commissioner may order any of the following:

1389 (1) Payment of a civil penalty of not more than one thousand five
1390 hundred dollars for each act or violation, provided such penalty shall
1391 not exceed an aggregate penalty of fifteen thousand dollars unless the
1392 company knew or reasonably should have known it was in violation of
1393 section 4 of this act, in which case the penalty shall be not more than
1394 seven thousand five hundred dollars for each act or violation, not to
1395 exceed an aggregate penalty of seventy-five thousand dollars in any
1396 six-month period;

1397 (2) Suspension or revocation of the utilization review company's
1398 license to do business in this state if it knew or reasonably should have
1399 known that it was in violation of section 4 of this act; or

1400 (3) Payment of such reasonable expenses as may be necessary to
1401 compensate the commissioner in connection with the proceedings
1402 under this subsection, which shall be dedicated exclusively to the
1403 regulation of utilization review.

1404 (c) Any company aggrieved by any such order of the commissioner
1405 may appeal therefrom in accordance with the provisions of section 4-
1406 183 of the general statutes, except venue for such appeal shall be in the
1407 judicial district of New Britain.

1408 (d) Any person who violates a cease and desist order of the
1409 commissioner made pursuant to this section and while such order is in
1410 effect shall, after notice and hearing and upon order of the
1411 commissioner, be subject to the following: (1) A civil penalty of not
1412 more than seventy-five thousand dollars; or (2) suspension or
1413 revocation of such person's license.

1414 Sec. 12. (NEW) (*Effective July 1, 2011*) (a) (1) The commissioner shall
1415 approve independent review organizations eligible to be assigned to
1416 conduct external reviews and expedited external reviews under section
1417 7 of this act.

1418 (2) The commissioner shall (A) develop an application form for the
1419 initial approval and for the reapproval of independent review
1420 organizations, and (B) maintain and periodically update a list of
1421 approved independent review organizations.

1422 (b) (1) Any independent review organization seeking to conduct
1423 external reviews and expedited external reviews under section 7 of this
1424 act shall submit the application form for approval or reapproval, as
1425 applicable, to the commissioner and shall include all documentation
1426 and information necessary for the commissioner to determine if the
1427 independent review organization satisfies the minimum qualifications
1428 established under this section.

1429 (2) An approval or reapproval shall be effective for two years,
1430 unless the commissioner determines before the expiration of such
1431 approval or reapproval that the independent review organization no
1432 longer satisfies the minimum qualifications established under this
1433 section.

1434 (3) Whenever the commissioner determines that an independent
1435 review organization has lost its accreditation or no longer satisfies the
1436 minimum requirements established under this section, the
1437 commissioner shall terminate the approval of the independent review
1438 organization and remove the independent review organization from
1439 the list of approved independent review organizations specified in
1440 subdivision (2) of subsection (a) of this section.

1441 (c) To be eligible for approval by the commissioner, an independent
1442 review organization shall:

1443 (1) Have and maintain written policies and procedures that govern
1444 all aspects of both the standard external review process and the

1445 expedited external review process set forth in section 7 of this act that
1446 include, at a minimum:

1447 (A) A quality assurance mechanism in place that ensures:

1448 (i) That external reviews and expedited external reviews are
1449 conducted within the specified time frames and required notices are
1450 provided in a timely manner;

1451 (ii) (I) The selection of qualified and impartial clinical peers to
1452 conduct such reviews on behalf of the independent review
1453 organization and the suitable matching of such peers to specific cases,
1454 and (II) employs or contracts with an adequate number of clinical
1455 peers to meet this objective;

1456 (iii) The confidentiality of medical and treatment records and
1457 clinical review criteria;

1458 (iv) That any person employed by or under contract with the
1459 independent review organization adheres to the requirements of
1460 section 7 of this act; and

1461 (B) A toll-free telephone number to receive information twenty-four
1462 hours a day, seven days a week, related to external reviews and
1463 expedited external reviews and that is capable of accepting, recording
1464 or providing appropriate instruction to incoming telephone callers
1465 during other than normal business hours;

1466 (2) Agree to maintain and provide to the commissioner the
1467 information set forth in section 13 of this act;

1468 (3) Not own or control, be a subsidiary of, be owned or controlled in
1469 any way by, or exercise control with a health benefit plan, a national,
1470 state or local trade association of health benefit plans, or a national,
1471 state or local trade association of health care professionals; and

1472 (4) Assign as a clinical peer a health care professional who meets the
1473 following minimum qualifications:

1474 (A) Is an expert in the treatment of the covered person's medical
1475 condition that is the subject of the review;

1476 (B) Is knowledgeable about the recommended health care service or
1477 treatment through recent or current actual clinical experience treating
1478 patients with the same or similar medical condition of the covered
1479 person;

1480 (C) Holds a nonrestricted license in a state of the United States and,
1481 for physicians, a current certification by a recognized American
1482 medical specialty board in the area or areas appropriate to the subject
1483 of the review; and

1484 (D) Has no history of disciplinary actions or sanctions, including
1485 loss of staff privileges or participation restrictions, that have been
1486 taken or are pending by any hospital, governmental agency or unit or
1487 regulatory body that raise a substantial question as to the clinical
1488 peer's physical, mental or professional competence or moral character.

1489 (d) (1) An independent review organization that is accredited by a
1490 nationally recognized private accrediting entity that has independent
1491 review accreditation standards that the commissioner has determined
1492 are equivalent to or exceed the minimum qualifications of this section
1493 shall be presumed to be in compliance with this section.

1494 (2) The commissioner shall initially review and periodically review
1495 the independent review organization accreditation standards of a
1496 nationally recognized private accrediting entity to determine whether
1497 such entity's standards are, and continue to be, equivalent to or exceed
1498 the minimum qualifications established under this section. The
1499 commissioner may accept a review conducted by the National
1500 Association of Insurance Commissioners for the purpose of the
1501 determination under this subdivision.

1502 (3) Upon request, a nationally recognized private accrediting entity
1503 shall make its current independent review organization accreditation
1504 standards available to the commissioner or the National Association of

1505 Insurance Commissioners in order for the commissioner to determine
1506 if such entity's standards are equivalent to or exceed the minimum
1507 qualifications established under this section. The commissioner may
1508 exclude any private accrediting entity that is not reviewed by the
1509 National Association of Insurance Commissioners.

1510 Sec. 13. (NEW) (*Effective July 1, 2011*) (a) The commissioner shall not
1511 assign an independent review organization, and no independent
1512 review organization shall assign a clinical peer, to conduct an external
1513 review or an expedited external review of a specified case if such
1514 organization or clinical peer has a material professional, familial or
1515 financial conflict of interest with any of the following:

1516 (1) The health carrier that is the subject of such review;

1517 (2) The covered person whose treatment is the subject of such
1518 review or the covered person's authorized representative;

1519 (3) Any officer, director or management employee of the health
1520 carrier that is the subject of such review;

1521 (4) The health care provider, the health care provider's medical
1522 group or independent practice association recommending the health
1523 care service or treatment that is the subject of such review;

1524 (5) The facility at which the recommended health care service or
1525 treatment would be provided; or

1526 (6) The developer or manufacturer of the principal drug, device,
1527 procedure or other therapy being recommended for the covered
1528 person whose treatment is the subject of such review.

1529 (b) To determine whether an independent review organization or a
1530 clinical peer of the independent review organization has a material
1531 professional, familial or financial conflict of interest for purposes of
1532 subsection (a) of this section, the commissioner shall consider
1533 situations in which the independent review organization to be
1534 assigned to conduct an external review or an expedited external

1535 review of a specified case or a clinical peer to be assigned by the
1536 independent review organization to conduct such review of a specified
1537 case may have an apparent professional, familial or financial
1538 relationship or connection with a person described in subsection (a) of
1539 this section, but the characteristics of such relationship or connection
1540 are such that they are not a material professional, familial or financial
1541 conflict of interest that results in the disapproval of the independent
1542 review organization or the clinical peer from conducting such review.

1543 (c) An independent review organization shall be unbiased. In
1544 addition to any other written procedures required under section 12 of
1545 this act, an independent review organization shall establish and
1546 maintain written procedures to ensure that it is unbiased.

1547 (d) No independent review organization or clinical peer working on
1548 behalf of an independent review organization or an employee, agent or
1549 contractor of an independent review organization shall be liable in
1550 damages to any person for any opinions rendered or acts or omissions
1551 performed within the scope of the organization's or person's duties
1552 during or upon completion of an external review or an expedited
1553 external review conducted pursuant to section 7 of this act, unless such
1554 opinion was rendered or act or omission performed in bad faith or
1555 involved gross negligence.

1556 (e) (1) Each independent review organization assigned by the
1557 commissioner to conduct a review pursuant to section 7 of this act
1558 shall maintain written records of all external reviews, whether
1559 standard or expedited external reviews, conducted by such
1560 organization in a calendar year. Such organization shall maintain such
1561 records in the aggregate by state where the covered person requesting
1562 such review resides and by health carrier, and shall submit a report to
1563 the commissioner upon request, in a format prescribed by the
1564 commissioner.

1565 (2) Such report shall include, in the aggregate by state where the
1566 covered person requesting such review resides and by health carrier:

1567 (A) The total number of requests for an external review, whether
1568 such requests were for a standard or an expedited external review;

1569 (B) The number of such requests resolved and, of those resolved, the
1570 number resolved upholding the adverse determination or final adverse
1571 determination and the number resolved reversing the adverse
1572 determination or final adverse determination;

1573 (C) The average length of time for resolution;

1574 (D) A summary of the types of coverages or cases for which a
1575 review was sought;

1576 (E) The number of such reviews that were terminated as a result of
1577 reconsideration by the health carrier of its adverse determination or
1578 final adverse determination after the receipt of additional information
1579 from the covered person or the covered person's authorized
1580 representative; and

1581 (F) Any other information the commissioner may request or require.

1582 (3) Each independent review organization shall retain the written
1583 records required pursuant to subdivision (1) of this subsection for not
1584 less than six years after the assignment of an external review or an
1585 expedited external review.

1586 (f) The commissioner shall adopt regulations, in accordance with
1587 chapter 54, to carry out the provisions of this section and sections 10 to
1588 12, inclusive, of this act.

1589 Sec. 14. Section 38a-478 of the general statutes is repealed and the
1590 following is substituted in lieu thereof (*Effective July 1, 2011*):

1591 As used in this section, sections [38a-478] 38a-478a to 38a-478o,
1592 inclusive, as amended by this act, and subsection (a) of section 38a-
1593 478s, as amended by this act:

1594 [(1) "Adverse determination" means a determination by a managed

1595 care organization, health insurer or utilization review company that an
1596 admission, service, procedure or extension of stay that is a covered
1597 benefit has been reviewed and, based upon the information provided,
1598 does not meet the managed care organization's, health insurer's or
1599 utilization review company's requirements for medical necessity,
1600 appropriateness, health care setting, level of care or effectiveness, and
1601 such requested admission, service, procedure or extension of stay, or
1602 payment for such admission, service, procedure or extension of stay
1603 has been denied, reduced or terminated.]

1604 [(2)] (1) "Commissioner" means the Insurance Commissioner.

1605 [(3)] (2) "Covered benefit" or "benefit" means a health care service to
1606 which an enrollee is entitled under the terms of a health benefit plan.

1607 [(4)] (3) [Except as provided in sections 38a-478m and 38a-478n,
1608 "enrollee"] "Enrollee" means a person who has contracted for or who
1609 participates in a managed care plan for such person or such person's
1610 eligible dependents.

1611 [(5)] (4) "Health care services" means services for the diagnosis,
1612 prevention, treatment, cure or relief of a health condition, illness,
1613 injury or disease.

1614 [(6)] (5) "Managed care organization" means an insurer, health care
1615 center, hospital or medical service corporation or other organization
1616 delivering, issuing for delivery, renewing, amending or continuing any
1617 individual or group health managed care plan in this state.

1618 [(7)] (6) "Managed care plan" means a product offered by a managed
1619 care organization that provides for the financing or delivery of health
1620 care services to persons enrolled in the plan through: (A)
1621 Arrangements with selected providers to furnish health care services;
1622 (B) explicit standards for the selection of participating providers; (C)
1623 financial incentives for enrollees to use the participating providers and
1624 procedures provided for by the plan; or (D) arrangements that share
1625 risks with providers, provided the organization offering a plan

1626 described under subparagraph (A), (B), (C) or (D) of this subdivision is
1627 licensed by the Insurance Department pursuant to chapter 698, 698a or
1628 700 and the plan includes utilization review, [pursuant to sections 38a-
1629 226 to 38a-226d, inclusive] as defined in section 1 of this act.

1630 [(8)] (7) "Preferred provider network" has the same meaning as
1631 provided in section 38a-479aa, as amended by this act.

1632 [(9)] (8) "Provider" or "health care provider" means a person licensed
1633 to provide health care services under chapters 370 to 373, inclusive, 375
1634 to 383c, inclusive, 384a to 384c, inclusive, or chapter 400j.

1635 [(10)] "Review entity" means an entity that conducts independent
1636 external reviews of adverse determinations. Such review entities
1637 include, but are not limited to, medical peer review organizations,
1638 independent utilization review companies, provided such
1639 organizations or companies are not related to or associated with any
1640 managed care organization or health insurer, and nationally
1641 recognized health experts or institutions approved by the Insurance
1642 Commissioner.]

1643 [(11)] (9) "Utilization review" has the same meaning as provided in
1644 section [38a-226] 1 of this act.

1645 [(12)] (10) "Utilization review company" has the same meaning as
1646 provided in section [38a-226] 1 of this act.

1647 Sec. 15. Subsection (c) of section 38a-19 of the general statutes is
1648 repealed and the following is substituted in lieu thereof (*Effective July*
1649 *1, 2011*):

1650 (c) The provisions of this section shall not apply to an order or
1651 decision of the commissioner made pursuant to section [38a-477b or
1652 38a-478n] 7 of this act.

1653 Sec. 16. Subsection (b) of section 38a-477b of the general statutes is
1654 repealed and the following is substituted in lieu thereof (*Effective July*
1655 *1, 2011*):

1656 (b) An insurer or health care center shall apply for approval of such
1657 rescission, cancellation or limitation by submitting such written
1658 information to the Insurance Commissioner on an application in such
1659 form as the commissioner prescribes. Such insurer or health care center
1660 shall provide a copy of the application for such approval to the insured
1661 or the insured's representative. Not later than seven business days
1662 after receipt of the application for such approval, the insured or the
1663 insured's representative shall have an opportunity to review such
1664 application and respond and submit relevant information to the
1665 commissioner with respect to such application. Not later than fifteen
1666 business days after the submission of information by the insured or the
1667 insured's representative, the commissioner shall issue a written
1668 decision on such application. The commissioner [may] shall only
1669 approve; [such rescission, cancellation]

1670 (1) Such rescission or limitation if the commissioner finds that [(1)]
1671 (A) the insured or such insured's representative submitted the written
1672 information [submitted] on or with the insurance application that was
1673 [false] fraudulent at the time such application was made, [and] (B) the
1674 insured or such insured's representative [knew or should have known
1675 of the falsity] intentionally misrepresented information therein [,] and
1676 such [submission] misrepresentation materially affects the risk or the
1677 hazard assumed by the insurer or health care center, or [(2)] (C) the
1678 information omitted from the insurance application was [knowingly]
1679 intentionally omitted by the insured or such insured's representative [,
1680 or the insured or such insured's representative should have known of
1681 such omission,] and such omission materially affects the risk or the
1682 hazard assumed by the insurer or health care center. Such decision
1683 shall be mailed to the insured, the insured's representative, if any, and
1684 the insurer or health care center; and

1685 (2) Such cancellation in accordance with the provisions set forth in
1686 the Public Health Service Act, 42 USC 300gg et seq., as amended from
1687 time to time.

1688 Sec. 17. Section 38a-478a of the general statutes is repealed and the

1689 following is substituted in lieu thereof (*Effective July 1, 2011*):

1690 On March [1, 1999, and] first annually, [thereafter,] the Insurance
1691 Commissioner shall submit a report [,] to the Governor and to the joint
1692 standing committees of the General Assembly having cognizance of
1693 matters relating to public health and [relating to] insurance,
1694 concerning the commissioner's responsibilities under the provisions of
1695 sections [38a-226 to 38a-226d, inclusive] 1 to 8, inclusive, of this act,
1696 38a-478 to 38a-478u, inclusive, as amended by this act, 38a-479aa, as
1697 amended by this act, and 38a-993. The report shall include: (1) A
1698 summary of the quality assurance plans submitted by managed care
1699 organizations pursuant to section 38a-478c along with suggested
1700 changes to improve such plans; (2) suggested modifications to the
1701 consumer report card developed under the provisions of section 38a-
1702 478l; (3) a summary of the commissioner's procedures and activities in
1703 conducting market conduct examinations of utilization review
1704 companies and preferred provider networks, including, but not limited
1705 to: (A) The number of desk and field audits completed during the
1706 previous calendar year; (B) a summary of findings of the desk and field
1707 audits, including any recommendations made for improvements or
1708 modifications; (C) a description of complaints concerning managed
1709 care companies, and any preferred provider network that provides
1710 services to enrollees on behalf of the managed care organization,
1711 including a summary and analysis of any trends or similarities found
1712 in the managed care complaints filed by enrollees; (4) a summary of
1713 the complaints concerning managed care organizations received by the
1714 Insurance Department's Consumer Affairs Division and the
1715 commissioner under section [38a-478n] 7 of this act, including a
1716 summary and analysis of any trends or similarities found in the
1717 complaints received; (5) a summary of any violations the commissioner
1718 has found against any managed care organization or any preferred
1719 provider network that provides services to enrollees on behalf of the
1720 managed care organization; and (6) a summary of the issues discussed
1721 related to health care or managed care organizations at the Insurance
1722 Department's quarterly forums throughout the state.

1723 Sec. 18. Section 38a-478b of the general statutes is repealed and the
1724 following is substituted in lieu thereof (*Effective July 1, 2011*):

1725 (a) Each managed care organization, as defined in section 38a-478,
1726 that fails to file the data, reports or information required by sections
1727 [38a-226 to 38a-226d] 1 to 8, inclusive, of this act, 38a-478 to 38a-478u,
1728 inclusive, as amended by this act, 38a-479aa, as amended by this act,
1729 and 38a-993 shall pay a late fee of one hundred dollars per day for each
1730 day from the due date of such data, reports or information to the date
1731 of filing. Each managed care organization that files incomplete data,
1732 reports or information shall be so informed by the commissioner, shall
1733 be given a date by which to remedy such incomplete filing and shall
1734 pay said late fee commencing from the new due date.

1735 (b) On June [1, 1998, and] first annually, [thereafter,] the
1736 commissioner shall submit [.] to the Governor and to the joint standing
1737 committees of the General Assembly having cognizance of matters
1738 relating to public health and [matters relating to] insurance, a list of
1739 those managed care organizations that have failed to file any data,
1740 report or information required by sections [38a-226 to 38a-226d] 1 to 8,
1741 inclusive, of this act, 38a-478 to 38a-478u, inclusive, as amended by this
1742 act, 38a-479aa, as amended by this act, and 38a-993.

1743 Sec. 19. Section 38a-478h of the general statutes is repealed and the
1744 following is substituted in lieu thereof (*Effective July 1, 2011*):

1745 (a) Each contract delivered, issued for delivery, renewed, amended
1746 or continued in this state [on and after October 1, 1997,] between a
1747 managed care organization and a participating provider shall require
1748 the provider to give at least sixty days' advance written notice to the
1749 managed care organization and shall require the managed care
1750 organization to give at least sixty days' advance written notice to the
1751 provider in order to withdraw from or terminate the agreement.

1752 (b) The provisions of this section shall not apply: (1) When lack of
1753 such notice is necessary for the health or safety of the enrollees; (2)
1754 when a provider has entered into a contract with a managed care

1755 organization that is found to be based on fraud or material
1756 misrepresentation; or (3) when a provider engages in any fraudulent
1757 activity related to the terms of his contract with the managed care
1758 organization.

1759 (c) No managed care organization shall take or threaten to take any
1760 action against any provider in retaliation for such provider's assistance
1761 to an enrollee under the provisions of [subsection (e) of section 38a-
1762 226c or section 38a-478n] section 7 of this act.

1763 Sec. 20. Subsection (d) of section 38a-478r of the general statutes is
1764 repealed and the following is substituted in lieu thereof (*Effective July*
1765 *1, 2011*):

1766 (d) The Insurance Commissioner [, after consultation with the
1767 working group convened pursuant to section 38a-478p,] may develop
1768 and disseminate to hospitals in this state a claims form system that will
1769 ensure that all hospitals consistently code for the presenting and
1770 diagnosis symptoms on all emergency claims.

1771 Sec. 21. Section 38a-478s of the general statutes is repealed and the
1772 following is substituted in lieu thereof (*Effective July 1, 2011*):

1773 (a) Nothing in sections 38a-478 to 38a-478o, inclusive, as amended
1774 by this act, or sections 1 to 8, inclusive, of this act shall be construed to
1775 apply to the arrangements of managed care organizations or health
1776 insurers offered to individuals covered under self-insured employee
1777 welfare benefit plans established pursuant to the federal Employee
1778 Retirement Income Security Act of 1974.

1779 (b) The provisions of sections 38a-478 to 38a-478o, inclusive, as
1780 amended by this act, and sections 1 to 8, inclusive, of this act shall not
1781 apply to any plan that provides for the financing or delivery of health
1782 care services solely for the purposes of workers' compensation benefits
1783 pursuant to chapter 568.

1784 Sec. 22. Section 38a-478t of the general statutes is repealed and the

1785 following is substituted in lieu thereof (*Effective July 1, 2011*):

1786 The Commissioner of Public Health may request and shall receive
1787 any data, report or information filed with the Insurance Commissioner
1788 pursuant to the provisions of sections [38a-226 to 38a-226d, inclusive]
1789 10 and 11 of this act, 38a-478 to 38a-478u, inclusive, as amended by this
1790 act, 38a-479aa, as amended by this act, and 38a-993.

1791 Sec. 23. Section 38a-478u of the general statutes is repealed and the
1792 following is substituted in lieu thereof (*Effective July 1, 2011*):

1793 The Insurance Commissioner may adopt regulations in accordance
1794 with the provisions of chapter 54 to implement the provisions of
1795 sections [38a-226 to 38a-226d, inclusive,] 38a-478 to 38a-478u, inclusive,
1796 as amended by this act, 38a-479aa, as amended by this act, and 38a-
1797 993.

1798 Sec. 24. Section 38a-479aa of the general statutes is repealed and the
1799 following is substituted in lieu thereof (*Effective July 1, 2011*):

1800 (a) As used in this part and subsection (b) of section 20-138b:

1801 (1) "Covered benefits" means health care services to which an
1802 enrollee is entitled under the terms of a managed care plan;

1803 (2) "Enrollee" means an individual who is eligible to receive health
1804 care services through a preferred provider network;

1805 (3) "Health care services" means health care related services or
1806 products rendered or sold by a provider within the scope of the
1807 provider's license or legal authorization, and includes hospital,
1808 medical, surgical, dental, vision and pharmaceutical services or
1809 products;

1810 (4) "Managed care organization" means (A) a managed care
1811 organization, as defined in section 38a-478, as amended by this act, (B)
1812 any other health insurer, or (C) a reinsurer with respect to health
1813 insurance;

1814 (5) "Managed care plan" means a managed care plan, as defined in
1815 section 38a-478, as amended by this act;

1816 (6) "Person" means an individual, agency, political subdivision,
1817 partnership, corporation, limited liability company, association or any
1818 other entity;

1819 (7) "Preferred provider network" means a person, which is not a
1820 managed care organization, but which pays claims for the delivery of
1821 health care services, accepts financial risk for the delivery of health
1822 care services and establishes, operates or maintains an arrangement or
1823 contract with providers relating to (A) the health care services
1824 rendered by the providers, and (B) the amounts to be paid to the
1825 providers for such services. "Preferred provider network" does not
1826 include (i) a workers' compensation preferred provider organization
1827 established pursuant to section 31-279-10 of the regulations of
1828 Connecticut state agencies, (ii) an independent practice association or
1829 physician hospital organization whose primary function is to contract
1830 with insurers and provide services to providers, (iii) a clinical
1831 laboratory, licensed pursuant to section 19a-30, whose primary
1832 payments for any contracted or referred services are made to other
1833 licensed clinical laboratories or for associated pathology services, or
1834 (iv) a pharmacy benefits manager responsible for administering
1835 pharmacy claims whose primary function is to administer the
1836 pharmacy benefit on behalf of a health benefit plan;

1837 (8) "Provider" means an individual or entity duly licensed or legally
1838 authorized to provide health care services; and

1839 (9) "Commissioner" means the Insurance Commissioner.

1840 (b) On and after May 1, 2004, no preferred provider network may
1841 enter into or renew a contractual relationship with a managed care
1842 organization unless the preferred provider network is licensed by the
1843 commissioner. On and after May 1, 2005, no preferred provider
1844 network may conduct business in this state unless it is licensed by the
1845 commissioner. Any person seeking to obtain or renew a license shall

1846 submit an application to the commissioner, on such form as the
1847 commissioner may prescribe, and shall include the filing described in
1848 this subsection, except that a person seeking to renew a license may
1849 submit only the information necessary to update its previous filing.
1850 Applications shall be submitted by March first of each year in order to
1851 qualify for the May first license issue or renewal date. The filing
1852 required from such preferred provider network shall include the
1853 following information: (1) The identity of the preferred provider
1854 network and any company or organization controlling the operation of
1855 the preferred provider network, including the name, business address,
1856 contact person, a description of the controlling company or
1857 organization and, where applicable, the following: (A) A certificate
1858 from the Secretary of the State regarding the preferred provider
1859 network's and the controlling company's or organization's good
1860 standing to do business in the state; (B) a copy of the preferred
1861 provider network's and the controlling company's or organization's
1862 financial statement completed in accordance with sections 38a-53 and
1863 38a-54, as applicable, for the end of its most recently concluded fiscal
1864 year, along with the name and address of any public accounting firm
1865 or internal accountant which prepared or assisted in the preparation of
1866 such financial statement; (C) a list of the names, official positions and
1867 occupations of members of the preferred provider network's and the
1868 controlling company's or organization's board of directors or other
1869 policy-making body and of those executive officers who are
1870 responsible for the preferred provider network's and controlling
1871 company's or organization's activities with respect to the health care
1872 services network; (D) a list of the preferred provider network's and the
1873 controlling company's or organization's principal owners; (E) in the
1874 case of an out-of-state preferred provider network, controlling
1875 company or organization, a certificate that such preferred provider
1876 network, company or organization is in good standing in its state of
1877 organization; (F) in the case of a Connecticut or out-of-state preferred
1878 provider network, controlling company or organization, a report of the
1879 details of any suspension, sanction or other disciplinary action relating
1880 to such preferred provider network, or controlling company or

1881 organization in this state or in any other state; and (G) the identity,
1882 address and current relationship of any related or predecessor
1883 controlling company or organization. For purposes of this
1884 subparagraph, "related" means that a substantial number of the board
1885 or policy-making body members, executive officers or principal
1886 owners of both companies are the same; (2) a general description of the
1887 preferred provider network and participation in the preferred provider
1888 network, including: (A) The geographical service area of and the
1889 names of the hospitals included in the preferred provider network; (B)
1890 the primary care physicians, the specialty physicians, any other
1891 contracting providers and the number and percentage of each group's
1892 capacity to accept new patients; (C) a list of all entities on whose behalf
1893 the preferred provider network has contracts or agreements to provide
1894 health care services; (D) a table listing all major categories of health
1895 care services provided by the preferred provider network; (E) an
1896 approximate number of total enrollees served in all of the preferred
1897 provider network's contracts or agreements; (F) a list of subcontractors
1898 of the preferred provider network, not including individual
1899 participating providers, that assume financial risk from the preferred
1900 provider network and to what extent each subcontractor assumes
1901 financial risk; (G) a contingency plan describing how contracted health
1902 care services will be provided in the event of insolvency; and (H) any
1903 other information requested by the commissioner; and (3) the name
1904 and address of the person to whom applications may be made for
1905 participation.

1906 (c) Any person developing a preferred provider network, or
1907 expanding a preferred provider network into a new county, pursuant
1908 to this section and subsection (b) of section 20-138b, shall publish a
1909 notice, in at least one newspaper having a substantial circulation in the
1910 service area in which the preferred provider network operates or will
1911 operate, indicating such planned development or expansion. Such
1912 notice shall include the medical specialties included in the preferred
1913 provider network, the name and address of the person to whom
1914 applications may be made for participation and a time frame for

1915 making application. The preferred provider network shall provide the
1916 applicant with written acknowledgment of receipt of the application.
1917 Each complete application shall be considered by the preferred
1918 provider network in a timely manner.

1919 (d) (1) Each preferred provider network shall file with the
1920 commissioner and make available upon request from a provider the
1921 general criteria for its selection or termination of providers. Disclosure
1922 shall not be required of criteria deemed by the preferred provider
1923 network to be of a proprietary or competitive nature that would hurt
1924 the preferred provider network's ability to compete or to manage
1925 health care services. For purposes of this section, criteria is of a
1926 proprietary or competitive nature if it has the tendency to cause
1927 providers to alter their practice pattern in a manner that would
1928 circumvent efforts to contain health care costs and criteria is of a
1929 proprietary nature if revealing the criteria would cause the preferred
1930 provider network's competitors to obtain valuable business
1931 information.

1932 (2) If a preferred provider network uses criteria that have not been
1933 filed pursuant to subdivision (1) of this subsection to judge the quality
1934 and cost-effectiveness of a provider's practice under any specific
1935 program within the preferred provider network, the preferred
1936 provider network may not reject or terminate the provider
1937 participating in that program based upon such criteria until the
1938 provider has been informed of the criteria that the provider's practice
1939 fails to meet.

1940 (e) Each preferred provider network shall permit the Insurance
1941 Commissioner to inspect its books and records.

1942 (f) Each preferred provider network shall permit the commissioner
1943 to examine, under oath, any officer or agent of the preferred provider
1944 network or controlling company or organization with respect to the
1945 use of the funds of the preferred provider network, company or
1946 organization, and compliance with (1) the provisions of this part, and

1947 (2) the terms and conditions of its contracts to provide health care
1948 services.

1949 (g) Each preferred provider network shall file with the
1950 commissioner a notice of any material modification of any matter or
1951 document furnished pursuant to this part, and shall include such
1952 supporting documents as are necessary to explain the modification.

1953 (h) Each preferred provider network shall maintain a minimum net
1954 worth of either (1) the greater of (A) two hundred fifty thousand
1955 dollars, or (B) an amount equal to eight per cent of its annual
1956 expenditures as reported on its most recent financial statement
1957 completed and filed with the commissioner in accordance with
1958 sections 38a-53 and 38a-54, as applicable, or (2) another amount
1959 determined by the commissioner.

1960 (i) Each preferred provider network shall maintain or arrange for a
1961 letter of credit, bond, surety, reinsurance, reserve or other financial
1962 security acceptable to the commissioner for the exclusive use of paying
1963 any outstanding amounts owed participating providers in the event of
1964 insolvency or nonpayment except that any remaining security may be
1965 used for the purpose of reimbursing managed care organizations in
1966 accordance with subsection (b) of section 38a-479bb. Such outstanding
1967 amount shall be at least an amount equal to the greater of (1) an
1968 amount sufficient to make payments to participating providers for two
1969 months determined on the basis of the two months within the past
1970 year with the greatest amounts owed by the preferred provider
1971 network to participating providers, (2) the actual outstanding amount
1972 owed by the preferred provider network to participating providers, or
1973 (3) another amount determined by the commissioner. Such amount
1974 may be credited against the preferred provider network's minimum
1975 net worth requirements set forth in subsection (h) of this section. The
1976 commissioner shall review such security amount and calculation on a
1977 quarterly basis.

1978 (j) Each preferred provider network shall pay the applicable license

1979 or renewal fee specified in section 38a-11. The commissioner shall use
1980 the amount of such fees solely for the purpose of regulating preferred
1981 provider networks.

1982 (k) In no event, including, but not limited to, nonpayment by the
1983 managed care organization, insolvency of the managed care
1984 organization, or breach of contract between the managed care
1985 organization and the preferred provider network, shall a preferred
1986 provider network bill, charge, collect a deposit from, seek
1987 compensation, remuneration or reimbursement from, or have any
1988 recourse against an enrollee or an enrollee's designee, other than the
1989 managed care organization, for covered benefits provided, except that
1990 the preferred provider network may collect any copayments,
1991 deductibles or other out-of-pocket expenses that the enrollee is
1992 required to pay pursuant to the managed care plan.

1993 (l) Each contract or agreement between a preferred provider
1994 network and a participating provider shall contain a provision that if
1995 the preferred provider network fails to pay for health care services as
1996 set forth in the contract, the enrollee shall not be liable to the
1997 participating provider for any sums owed by the preferred provider
1998 network or any sums owed by the managed care organization because
1999 of nonpayment by the managed care organization, insolvency of the
2000 managed care organization or breach of contract between the managed
2001 care organization and the preferred provider network.

2002 (m) Each utilization review determination made by or on behalf of a
2003 preferred provider network shall be made in accordance with [sections
2004 38a-226 to 38a-226d, inclusive, except that any initial appeal of a
2005 determination not to certify an admission, service, procedure or
2006 extension of stay shall be conducted in accordance with subdivision (7)
2007 of subsection (a) of section 38a-226c, and any subsequent appeal shall
2008 be referred to the managed care organization on whose behalf the
2009 preferred provider network provides services. The managed care
2010 organization shall conduct the subsequent appeal in accordance with
2011 said subdivision] section 4 of this act.

2012 (n) The requirements of subsections (h) and (i) of this section shall
2013 not apply to a consortium of federally qualified health centers funded
2014 by the state, providing services only to recipients of programs
2015 administered by the Department of Social Services. The Commissioner
2016 of Social Services shall adopt regulations, in accordance with chapter
2017 54, to establish criteria to certify any such federally qualified health
2018 center, including, but not limited to, minimum reserve fund
2019 requirements.

2020 Sec. 25. Subsection (d) of section 38a-479bb of the general statutes is
2021 repealed and the following is substituted in lieu thereof (*Effective July*
2022 *1, 2011*):

2023 (d) Each managed care organization shall ensure that any contract it
2024 has with a preferred provider network includes:

2025 (1) A provision that requires the preferred provider network to
2026 provide to the managed care organization at the time a contract is
2027 entered into, annually, and upon request of the managed care
2028 organization, (A) the financial statement completed in accordance with
2029 sections 38a-53 and 38a-54, as applicable, and section 38a-479aa, as
2030 amended by this act; (B) documentation that satisfies the managed care
2031 organization that the preferred provider network has sufficient ability
2032 to accept financial risk; (C) documentation that satisfies the managed
2033 care organization that the preferred provider network has appropriate
2034 management expertise and infrastructure; (D) documentation that
2035 satisfies the managed care organization that the preferred provider
2036 network has an adequate provider network taking into account the
2037 geographic distribution of enrollees and participating providers and
2038 whether participating providers are accepting new patients; (E) an
2039 accurate list of participating providers; and (F) documentation that
2040 satisfies the managed care organization that the preferred provider
2041 network has the ability to ensure the delivery of health care services as
2042 set forth in the contract;

2043 (2) A provision that requires the preferred provider network to

2044 provide to the managed care organization a quarterly status report that
2045 includes (A) information updating the financial statement completed
2046 in accordance with sections 38a-53 and 38a-54, as applicable, and
2047 section 38a-479aa, as amended by this act; (B) a report showing
2048 amounts paid to those providers who provide health care services on
2049 behalf of the managed care organization; (C) an estimate of payments
2050 due providers but not yet reported by providers; (D) amounts owed to
2051 providers for that quarter; and (E) the number of utilization review
2052 determinations not to certify an admission, service, procedure or
2053 extension of stay made by or on behalf of the preferred provider
2054 network and the outcome of such determination on appeal;

2055 (3) A provision that requires the preferred provider network to
2056 provide notice to the managed care organization not later than five
2057 business days after (A) any change involving the ownership structure
2058 of the preferred provider network; (B) financial or operational
2059 concerns arise regarding the financial viability of the preferred
2060 provider network; or (C) the preferred provider network's loss of a
2061 license in this or any other state;

2062 (4) A provision that if the managed care organization fails to pay for
2063 health care services as set forth in the contract, the enrollee will not be
2064 liable to the provider or preferred provider network for any sums
2065 owed by the managed care organization or preferred provider
2066 network;

2067 (5) A provision that the preferred provider network shall include in
2068 all contracts between the preferred provider network and participating
2069 providers a provision that if the preferred provider network fails to
2070 pay for health care services as set forth in the contract, for any reason,
2071 the enrollee shall not be liable to the participating provider or
2072 preferred provider network for any sums owed by the preferred
2073 provider network or any sums owed by the managed care
2074 organization because of nonpayment by the managed care
2075 organization, insolvency of the managed care organization or breach of
2076 contract between the managed care organization and the preferred

2077 provider network;

2078 (6) A provision requiring the preferred provider network to provide
2079 information to the managed care organization, satisfactory to the
2080 managed care organization, regarding the preferred provider
2081 network's reserves for financial risk;

2082 (7) A provision that (A) the preferred provider network or managed
2083 care organization shall post and maintain a letter of credit, bond,
2084 surety, reinsurance, reserve or other financial security acceptable to the
2085 commissioner, in order to satisfy the risk accepted by the preferred
2086 provider network pursuant to the contract, in an amount calculated in
2087 accordance with subsection (i) of section 38a-479aa, as amended by this
2088 act, (B) the managed care organization shall determine who posts and
2089 maintains the security required under subparagraph (A) of this
2090 subdivision, and (C) in the event of insolvency or nonpayment, such
2091 security shall be used by the preferred provider network, or other
2092 entity designated by the commissioner, solely for the purpose of
2093 paying any outstanding amounts owed participating providers, except
2094 that any remaining security may be used for the purpose of
2095 reimbursing the managed care organization for any payments made by
2096 the managed care organization to participating providers on behalf of
2097 the preferred provider network;

2098 (8) A provision under which the managed care organization is
2099 permitted, at the discretion of the managed care organization, to pay
2100 participating providers directly and in lieu of the preferred provider
2101 network in the event of insolvency or mismanagement by the
2102 preferred provider network and that payments made pursuant to this
2103 subdivision may be made or reimbursed from the security posted
2104 pursuant to subsection (b) of this section;

2105 (9) A provision transferring and assigning contracts between the
2106 preferred provider network and participating providers to the
2107 managed care organization for the provision of future services by
2108 participating providers to enrollees, at the discretion of the managed

2109 care organization, in the event the preferred provider network (A)
2110 becomes insolvent, (B) otherwise ceases to conduct business, as
2111 determined by the commissioner, or (C) demonstrates a pattern of
2112 nonpayment of authorized claims, as determined by the commissioner,
2113 for a period in excess of ninety days;

2114 (10) A provision that each contract or agreement between the
2115 preferred provider network and participating providers shall include a
2116 provision transferring and assigning contracts between the preferred
2117 provider network and participating providers to the managed care
2118 organization for the provision of future health care services by
2119 participating providers to enrollees, at the discretion of the managed
2120 care organization, in the event the preferred provider network (A)
2121 becomes insolvent, (B) otherwise ceases to conduct business, as
2122 determined by the commissioner, or (C) demonstrates a pattern of
2123 nonpayment of authorized claims, as determined by the commissioner,
2124 for a period in excess of ninety days;

2125 (11) A provision that the preferred provider network shall pay for
2126 the delivery of health care services and operate or maintain
2127 arrangements or contracts with providers in a manner consistent with
2128 the provisions of law that apply to the managed care organization's
2129 contracts with enrollees and providers; and

2130 (12) A provision that the preferred provider network shall ensure
2131 that utilization review determinations are made in accordance with
2132 [sections 38a-226 to 38a-226d, inclusive, except that any initial appeal
2133 of a determination not to certify an admission, service, procedure or
2134 extension of stay shall be made in accordance with subdivision (7) of
2135 subsection (a) of section 38a-226c. In cases where an appeal to reverse a
2136 determination not to certify is unsuccessful, the preferred provider
2137 network shall refer the case to the managed care organization which
2138 shall conduct the subsequent appeal, if any, in accordance with said
2139 subdivision] section 4 of this act.

2140 Sec. 26. Section 38a-479ee of the general statutes is repealed and the

2141 following is substituted in lieu thereof (*Effective July 1, 2011*):

2142 (a) If the Insurance Commissioner determines that a preferred
2143 provider network or managed care organization, or both, has not
2144 complied with any applicable provision of this part [, sections 38a-226
2145 to 38a-226d, inclusive,] or sections 38a-815 to 38a-819, inclusive, as
2146 amended by this act, the commissioner may (1) order the preferred
2147 provider network or managed care organization, or both if both have
2148 not complied, to cease and desist all operations in violation of this part
2149 or said sections; (2) terminate or suspend the preferred provider
2150 network's license; (3) institute a corrective action against the preferred
2151 provider network or managed care organization, or both if both have
2152 not complied; (4) order the payment of a civil penalty by the preferred
2153 provider network or managed care organization, or both if both have
2154 not complied, of not more than one thousand dollars for each and
2155 every act or violation; (5) order the payment of such reasonable
2156 expenses as may be necessary to compensate the commissioner in
2157 conjunction with any proceedings held to investigate or enforce
2158 violations of this part [, sections 38a-226 to 38a-226d, inclusive,] or
2159 sections 38a-815 to 38a-819, inclusive, as amended by this act; and (6)
2160 use any of the commissioner's other enforcement powers to obtain
2161 compliance with this part [, sections 38a-226 to 38a-226d, inclusive,] or
2162 sections 38a-815 to 38a-819, inclusive, as amended by this act. The
2163 commissioner may hold a hearing concerning any matter governed by
2164 this part [, sections 38a-226 to 38a-226d, inclusive,] or sections 38a-815
2165 to 38a-819, inclusive, as amended by this act, in accordance with
2166 section 38a-16. Subject to the same confidentiality and liability
2167 protections set forth in subsections (c) and (k) of section 38a-14, the
2168 commissioner may engage the services of attorneys, appraisers,
2169 independent actuaries, independent certified public accountants or
2170 other professionals and specialists to assist the commissioner in
2171 conducting an investigation under this section, the cost of which shall
2172 be borne by the managed care organization or preferred provider
2173 network, or both, that is the subject of the investigation.

2174 (b) If a preferred provider network fails to comply with any

2175 applicable provision of this part [, sections 38a-226 to 38a-226d,
2176 inclusive,] or sections 38a-815 to 38a-819, inclusive, as amended by this
2177 act, the commissioner may assign or require the preferred provider
2178 network to assign its rights and obligations under any contract with
2179 participating providers in order to ensure that covered benefits are
2180 provided.

2181 (c) The commissioner shall receive and investigate (1) any grievance
2182 filed against a preferred provider network or managed care
2183 organization, or both, by an enrollee or an enrollee's designee
2184 concerning matters governed by this part [, sections 38a-226 to 38a-
2185 226d, inclusive,] or sections 38a-815 to 38a-819, inclusive, as amended
2186 by this act, or (2) any referral from the Office of the Healthcare
2187 Advocate pursuant to section 38a-1041, as amended by this act. The
2188 commissioner shall code, track and review such grievances and
2189 referrals. The preferred provider network or managed care
2190 organization, or both, shall provide the commissioner with all
2191 information necessary for the commissioner to investigate such
2192 grievances and referrals. The information collected by the
2193 commissioner pursuant to this section shall be maintained as
2194 confidential and shall not be disclosed to any person except (A) to the
2195 extent necessary to carry out the purposes of this part [, sections 38a-
2196 226 to 38a-226d, inclusive,] or sections 38a-815 to 38a-819, inclusive, as
2197 amended by this act, (B) as allowed under this title, (C) to the
2198 Healthcare Advocate, and (D) information concerning the nature of
2199 any grievance or referral and the commissioner's final determination
2200 shall be a public record, as defined in section 1-200, provided no
2201 personal information, as defined in section 38a-975, shall be disclosed.
2202 The commissioner shall report to the Healthcare Advocate on the
2203 resolution of any matter referred to the commissioner by the
2204 Healthcare Advocate.

2205 Sec. 27. Section 38a-479ff of the general statutes is repealed and the
2206 following is substituted in lieu thereof (*Effective July 1, 2011*):

2207 No health insurer, health care center, utilization review company, as

2208 defined in section [38a-226] 1 of this act, or preferred provider
2209 network, as defined in section 38a-479aa, as amended by this act, shall
2210 take or threaten to take any adverse personnel or coverage-related
2211 action against any enrollee, provider or employee in retaliation for
2212 such enrollee, provider or employee (1) filing a complaint with the
2213 Insurance Commissioner or the Office of the Healthcare Advocate, or
2214 (2) disclosing information to the Insurance Commissioner concerning
2215 any violation of this part [, sections 38a-226 to 38a-226d, inclusive,] or
2216 sections 38a-815 to 38a-819, inclusive, as amended by this act, unless
2217 such disclosure violates the provisions of chapter 705 or the privacy
2218 provisions of the federal Health Insurance Portability and
2219 Accountability Act of 1996, [(P.L. 104-191) (HIPAA)] P.L. 104-191, as
2220 amended from time to time, or regulations adopted thereunder. Any
2221 enrollee, provider or employee who is aggrieved by a violation of this
2222 section may bring a civil action in the Superior Court to recover
2223 damages and attorneys' fees and costs.

2224 Sec. 28. Section 38a-483c of the general statutes is repealed and the
2225 following is substituted in lieu thereof (*Effective July 1, 2011*):

2226 (a) Each individual health insurance policy delivered, issued for
2227 delivery, renewed, amended or continued in this state on or after
2228 January 1, 2000, shall define the extent to which it provides coverage
2229 for experimental treatments.

2230 (b) No such health insurance policy may deny a procedure,
2231 treatment or the use of any drug as experimental if such procedure,
2232 treatment or drug, for the illness or condition being treated, or for the
2233 diagnosis for which it is being prescribed, has successfully completed a
2234 phase III clinical trial of the federal Food and Drug Administration.

2235 (c) Any person who has been diagnosed with a condition that
2236 creates a life expectancy in that person of less than two years and who
2237 has been denied an otherwise covered procedure, treatment or drug on
2238 the grounds that it is experimental may request an expedited appeal as
2239 provided in section [38a-226c] 5 of this act and may appeal a denial

2240 thereof to the Insurance Commissioner in accordance with the
2241 procedures established in section [38a-478n] 7 of this act.

2242 [(d) For the purposes of conducting an appeal pursuant to section
2243 38a-478n on the grounds that an otherwise covered procedure,
2244 treatment or drug is experimental, the basis of such an appeal shall be
2245 the medical efficacy of such procedure, treatment or drug. The entity
2246 conducting the review may consider whether the procedure, treatment
2247 or drug (1) has been approved by the National Institute of Health or
2248 the American Medical Association, (2) is listed in the United States
2249 Pharmacopoeia Drug Information Guide for Health Care Professionals
2250 (USP-DI), the American Medical Association Drug Evaluations (AMA-
2251 DE), or the American Society of Hospital Pharmacists' American
2252 Hospital Formulary Service Drug Information (AHFS-DI), or (3) is
2253 currently in a phase III clinical trial of the federal Food and Drug
2254 Administration.]

2255 Sec. 29. Section 38a-513b of the general statutes is repealed and the
2256 following is substituted in lieu thereof (*Effective July 1, 2011*):

2257 (a) Each group health insurance policy delivered, issued for
2258 delivery, renewed, amended or continued in this state on or after
2259 January 1, 2000, shall define the extent to which it provides coverage
2260 for experimental treatments.

2261 (b) No such health insurance policy may deny a procedure,
2262 treatment or the use of any drug as experimental if such procedure,
2263 treatment or drug, for the illness or condition being treated, or for the
2264 diagnosis for which it is being prescribed, has successfully completed a
2265 phase III clinical trial of the federal Food and Drug Administration.

2266 (c) Any person who has been diagnosed with a condition that
2267 creates a life expectancy in that person of less than two years and who
2268 has been denied an otherwise covered procedure, treatment or drug on
2269 the grounds that it is experimental may request an expedited appeal as
2270 provided in section [38a-226c] 5 of this act and may appeal a denial
2271 thereof to the Insurance Commissioner in accordance with the

2272 procedures established in section [38a-478n] 7 of this act.

2273 [(d) For the purposes of conducting an appeal pursuant to section
2274 38a-478n on the grounds that an otherwise covered procedure,
2275 treatment or drug is experimental, the basis of such an appeal shall be
2276 the medical efficacy of such procedure, treatment or drug. The entity
2277 conducting the review may consider whether the procedure, treatment
2278 or drug (1) has been approved by the National Institute of Health or
2279 the American Medical Association, (2) is listed in the United States
2280 Pharmacopoeia Drug Information Guide for Health Care Professionals
2281 (USP-DI), the American Medical Association Drug Evaluations (AMA-
2282 DE), or the American Society of Hospital Pharmacists' American
2283 Hospital Formulary Service Drug Information (AHFS-DI), or (3) is
2284 currently in a phase III clinical trial of the federal Food and Drug
2285 Administration.]

2286 Sec. 30. Subsection (c) of section 38a-504f of the general statutes is
2287 repealed and the following is substituted in lieu thereof (*Effective July*
2288 *1, 2011*):

2289 (c) The insured, or the provider with the insured's written consent,
2290 may appeal any denial of coverage for medical necessity to an external,
2291 independent review pursuant to section [38a-478n] 7 of this act. Such
2292 external review shall be conducted by a properly qualified review
2293 agent whom the department has determined does not have a conflict
2294 of interest regarding the cancer clinical trial.

2295 Sec. 31. Subsection (c) of section 38a-542f of the general statutes is
2296 repealed and the following is substituted in lieu thereof (*Effective July*
2297 *1, 2011*):

2298 (c) The insured, or the provider with the insured's written consent,
2299 may appeal any denial of coverage for medical necessity to an external,
2300 independent review pursuant to section [38a-478n] 7 of this act. Such
2301 external review shall be conducted by a properly qualified review
2302 agent whom the department has determined does not have a conflict
2303 of interest regarding the cancer clinical trial.

2304 Sec. 32. Subdivision (22) of section 38a-816 of the general statutes is
2305 repealed and the following is substituted in lieu thereof (*Effective July*
2306 *1, 2011*):

2307 (22) Any violation of [section 38a-478m] sections 4 to 6, inclusive, of
2308 this act.

2309 Sec. 33. Subdivision (3) of section 38a-1040 of the general statutes is
2310 repealed and the following is substituted in lieu thereof (*Effective July*
2311 *1, 2011*):

2312 (3) "Managed care plan" means a product offered by a managed care
2313 organization that provides for the financing or delivery of health care
2314 services to persons enrolled in the plan through: (A) Arrangements
2315 with selected providers to furnish health care services; (B) explicit
2316 standards for the selection of participating providers; (C) financial
2317 incentives for enrollees to use the participating providers and
2318 procedures provided for by the plan; or (D) arrangements that share
2319 risks with providers, provided the organization offering a plan
2320 described under subparagraph (A), (B), (C) or (D) of this subdivision is
2321 licensed by the Insurance Department pursuant to chapter 698, 698a or
2322 700 and that the plan includes utilization review, [pursuant to sections
2323 38a-226 to 38a-226d, inclusive] as defined in section 1 of this act.

2324 Sec. 34. Subsections (b) and (c) of section 38a-1041 of the general
2325 statutes are repealed and the following is substituted in lieu thereof
2326 (*Effective July 1, 2011*):

2327 (b) The Office of the Healthcare Advocate may:

2328 (1) Assist health insurance consumers with managed care plan
2329 selection by providing information, referral and assistance to
2330 individuals about means of obtaining health insurance coverage and
2331 services;

2332 (2) Assist health insurance consumers to understand their rights and
2333 responsibilities under managed care plans;

2334 (3) Provide information to the public, agencies, legislators and
2335 others regarding problems and concerns of health insurance
2336 consumers and make recommendations for resolving those problems
2337 and concerns;

2338 (4) Assist consumers with the filing of complaints and appeals,
2339 including filing appeals with a managed care organization's internal
2340 appeal or grievance process and the external appeal process
2341 established under [section 38a-478n] sections 4 to 7, inclusive, of this
2342 act;

2343 (5) Analyze and monitor the development and implementation of
2344 federal, state and local laws, regulations and policies relating to health
2345 insurance consumers and recommend changes it deems necessary;

2346 (6) Facilitate public comment on laws, regulations and policies,
2347 including policies and actions of health insurers;

2348 (7) Ensure that health insurance consumers have timely access to the
2349 services provided by the office;

2350 (8) Review the health insurance records of a consumer who has
2351 provided written consent for such review;

2352 (9) Create and make available to employers a notice, suitable for
2353 posting in the workplace, concerning the services that the Healthcare
2354 Advocate provides;

2355 (10) Establish a toll-free number, or any other free calling option, to
2356 allow customer access to the services provided by the Healthcare
2357 Advocate;

2358 (11) Pursue administrative remedies on behalf of and with the
2359 consent of any health insurance consumers;

2360 (12) Adopt regulations, pursuant to chapter 54, to carry out the
2361 provisions of sections 38a-1040 to 38a-1050, inclusive, as amended by
2362 this act; and

2363 (13) Take any other actions necessary to fulfill the purposes of
 2364 sections 38a-1040 to 38a-1050, inclusive, as amended by this act.

2365 (c) The Office of the Healthcare Advocate shall make a referral to
 2366 the Insurance Commissioner if the Healthcare Advocate finds that a
 2367 preferred provider network may have engaged in a pattern or practice
 2368 that may be in violation of sections [38a-226 to 38a-226d, inclusive,]
 2369 38a-479aa to 38a-479gg, inclusive, as amended by this act, or 38a-815 to
 2370 38a-819, inclusive, as amended by this act.

2371 Sec. 35. (*Effective July 1, 2011*) Notwithstanding the provisions of
 2372 sections 38a-183, 38a-481 and 38a-513 of the general statutes, a health
 2373 carrier, as defined in section 1 of this act, shall certify to the Insurance
 2374 Commissioner, in a form and manner prescribed by said
 2375 commissioner, that any forms or endorsements relating to utilization
 2376 review, the health carrier's internal grievance process, external review
 2377 or expedited external review that are filed by such health carrier
 2378 pursuant to section 38a-183, 38a-481 or 38a-513 of the general statutes
 2379 for use on or after July 1, 2011, are in compliance with sections 1 to 13,
 2380 inclusive, of this act and the Patient Protection and Affordable Care
 2381 Act, P.L. 111-148, as amended from time to time, and any regulations
 2382 adopted thereunder. Upon receipt by said commissioner of such filing
 2383 and certification, the health carrier may use such forms or
 2384 endorsements until such time as said commissioner, after notice and
 2385 hearing, disapproves their use. A health carrier may use the
 2386 certification procedure as set forth in this section until June 30, 2012.

2387 Sec. 36. Sections 38a-226 to 38a-226d, inclusive, 38a-478m, 38a-478n
 2388 and 38a-478p of the general statutes are repealed. (*Effective July 1,*
 2389 *2011*)"

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>July 1, 2011</i>	New section
Sec. 2	<i>July 1, 2011</i>	New section
Sec. 3	<i>July 1, 2011</i>	New section

Sec. 4	July 1, 2011	New section
Sec. 5	July 1, 2011	New section
Sec. 6	July 1, 2011	New section
Sec. 7	July 1, 2011	New section
Sec. 8	July 1, 2011	New section
Sec. 9	July 1, 2011	New section
Sec. 10	July 1, 2011	New section
Sec. 11	July 1, 2011	New section
Sec. 12	July 1, 2011	New section
Sec. 13	July 1, 2011	New section
Sec. 14	July 1, 2011	38a-478
Sec. 15	July 1, 2011	38a-19(c)
Sec. 16	July 1, 2011	38a-477b(b)
Sec. 17	July 1, 2011	38a-478a
Sec. 18	July 1, 2011	38a-478b
Sec. 19	July 1, 2011	38a-478h
Sec. 20	July 1, 2011	38a-478r(d)
Sec. 21	July 1, 2011	38a-478s
Sec. 22	July 1, 2011	38a-478t
Sec. 23	July 1, 2011	38a-478u
Sec. 24	July 1, 2011	38a-479aa
Sec. 25	July 1, 2011	38a-479bb(d)
Sec. 26	July 1, 2011	38a-479ee
Sec. 27	July 1, 2011	38a-479ff
Sec. 28	July 1, 2011	38a-483c
Sec. 29	July 1, 2011	38a-513b
Sec. 30	July 1, 2011	38a-504f(c)
Sec. 31	July 1, 2011	38a-542f(c)
Sec. 32	July 1, 2011	38a-816(22)
Sec. 33	July 1, 2011	38a-1040(3)
Sec. 34	July 1, 2011	38a-1041(b) and (c)
Sec. 35	July 1, 2011	New section
Sec. 36	July 1, 2011	Repealer section